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# RURAL HEALTH CARE IN OKLAHOMA

## HEARING

BEFORE THE

## SPECIAL COMMITTEE ON AGING
## UNITED STATES SENATE

NINETY-NINTH CONGRESS

FIRST SESSION

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OKLAHOMA CITY, OK

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APRIL 9, 1985

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# RURAL HEALTH CARE IN OKLAHOMA

TUESDAY, APRIL 9, 1985

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
*Oklahoma City, OK.*

The committee met, pursuant to notice, in the Baptist Medical Center, Oklahoma City, OK, Hon. Don Nickles presiding.

Present: Senator Nickles.

Also present: Laura Clay, legislative director to Senator Nickles.

## OPENING STATEMENT BY SENATOR DON NICKLES

Senator NICKLES. I want to thank all of you for attending this morning. I especially want to thank Phil Newbold and James Henry back in the corner, the administrators at Baptist Memorial, for their hospitality in allowing us the use of this excellent facility for the hearing this morning.

In today's hearing we will focus on rural health care, particularly rural health care providers and the status of rural health care. This is a continuation of hearings that I've had throughout the State dealing with health care issues.

We had hearings in Tulsa with Senator Durenberger, who is on the Finance Committee, on general oversight on health care issues. We've had health care hearings on organ transplants.

And I might mention that I just visited the latest heart transplant patient in Oklahoma—he is doing exceptionally well, and it's exciting to me to see real progress being made in this area. I'm also very proud now that Oklahoma is one of the States doing transplants at Baptist Memorial Hospital. Dr. Zuhdi is doing an outstanding job, and we've already had successful heart transplants.

I've been involved in the organ donor issue and am trying to make more people aware of the necessity for donors. There has been some success although we still have a long way to go. We still have a lot of people who are on the waiting list for various organs, and I hope that Oklahomans and people throughout the country will get more interested and check their donor cards.

Today we're going to focus primarily on health care in the rural areas. You don't have to be a professional in the health care field to know that right now there's a revolution going on in how our country pays for and provides for health care. Businesses and patients, government officials, taxpayers, and families are becoming keenly aware that many changes are now occurring.

Although this change is due to many factors, the most significant impetus has been the soaring cost of health care over the last 15 years. Here it is significant to note that when Medicare was en-

acted in 1962 it was expected to cost about $8.8 billion in 1990. The new projection for 1990 is close to $100 billion. The same explosion of cost is true for the private sector as well.

In response to these uncontrolled increases, consumers have started to put new pressures on hospitals, physicians, and insurers to contain costs. Most significant has been the change in the way Medicare, which pays for about 40 percent of the Nation's hospital bills, reimburses hospitals.

There is a cap on the amount a hospital can receive per patient. If the hospital can make their cost less than that amount; then they can pocket the difference. If they're over that payment level, they must eat the cost overrun. Private insurers through DRG's and HMO's are doing basically the same thing.

Obviously such a drastic change in the incentives the hospitals and doctors have affects all hospitals, and so today we are going to focus primarily on rural hospitals because they are impacted even greater. In some instances entire communities are at risk of having little or no access to health care services.

The Senate Special Committee on Aging has an interest in this issue because of its impact especially on the elderly. Oklahoma has the 12th highest concentration of elderly in the country. A large portion of the over-65 population live in rural portions of our State. These are folks who are most likely to need immediate care in their community and are most at risk if care is not available. Today we'll hear from some of the concerns of senior citizens on this point.

There are a number of reasons why rural hospitals are hit harder by the changes in the health care industry. First is simply their size and also their patient population. Smaller hospitals with 15 to 30, maybe 40 beds, have less room to make up for cost overrun. All hospitals will on occasion take in patients who cannot pay for treatment, which is also very expensive. This happens under Medicare, Medicaid, and those who, for one reason or another, fall between the cracks. At least a larger hospital has some more room to make up for cases through other patients.

For smaller hospitals, however, one very expensive case could be devastating. This is especially true because in the rural areas we have a much higher percentage of patients who are on Medicaid and Medicare and also are indigent.

We'll hear from Holdenville and Wetumka today where unemployment is higher than average in the State. It's easy to see how such economic distress endangers that community's access to health care if the hospital can't collect payment.

The smaller hospitals also are less able to absorb significant decreases in occupancy rates. There are some hospitals that have less than five patients in them today and yet they're making monthly payments on billing debts that are as high as a million dollars. No institution can survive if they have that type of an imbalance.

The other major contributing factor for the unique plight of small rural hospitals is the Federal Government. Somewhere in the minds of the number crunchers in Washington, DC, they get the idea that a tonsillectomy ought to have a different price tag on it in Oklahoma as compared to New York. Not only are there var-

iances between States, but there are also large variances between communities and hospitals within the State of Oklahoma.

In my travels throughout the State, I was shocked when I started asking a variety of hospital administrators what they received under the DRG system and how that compared with other hospitals in the State of Oklahoma.

I was in Buffalo, OK. Buffalo is like many of the rural hospital areas in Oklahoma. Their hospital is encountering difficult times. And this happens to be a hospital that's paid for, so it's not one that is just swamped by debt.

But looking at the reimbursement ratios in Buffalo and how they compare to an urban Oklahoma hospital is a difference of night and day. For an appendectomy in Enid, OK, the DRG is $3,092. In Buffalo, OK, it's half that amount, $1,538. In Okeene, OK, another rural hospital, that's $1,752.

For a hernia operation in Enid, OK, the reimbursement rate was $1,673. In Okeene, which is not that far from Enid, it is $948. And in Buffalo, OK, it's $832. Again, in Buffalo it's half the reimbursement rate of what it is in Enid.

I can't see that a hernia operation would be that much different between a rural hospital and an urban hospital.

The discrepancies that we see occurring, not just in this instance but in the other hundreds of DRG's throughout the State, are enormous, and particularly much smaller for the rural hospitals. The effect has been an increased pressure on those in the rural areas.

This is what we're going to focus on today: Some of the discrepancies that we find and some possibilities for closing that discrepancy. Also, how we might be able to come up with some Government policies to help rural hospital care and rural medical care for people in the State of Oklahoma.

As I mentioned before, Oklahoma has a very high percentage of elderly in the State, and so I think it's awfully important that you look at the demographics of our State. We have a lot of people who are dependent on rural health care. They don't have a lot of time to make it into the urban areas for emergency care.

Also, I think we want to focus on Federal policy. Do we really want to have the current policy that reimburses hospitals and physicians more in the urban areas, effectively penalizing those in the rural areas?

If you take that philosophy and extend it over a long period of time, I think we could see an evolution toward more and more health care centered only in the larger cities and less health care in the more rural areas. To me, that's not a very sound health policy for the Federal level and one that I intend to become much more active in redirecting.

I might ask a question today. We have a lot of visitors that came from throughout the State. How many are from the Oklahoma City area? How many are from outside of the Oklahoma City area? How many of you traveled more than 50 miles? Quite a lot of you. Well, I appreciate your time and efforts. I know all of you are busy and I know all of you have a lot of things on your mind.

We have a witness list today of 10 panelists. If possible, at the conclusion of their statements and question and answers, we'll open up the hearing for additional comments, because I'm sure

that there are a lot of people that are quite concerned about the issue and have some comments that they would like to make.

Most of you know Laura Clay of my staff. Laura is my legislative director. She's also been in charge of our legislative efforts in the health care field for the last 4 years.

I'm a member of two committees that deal with health care, as I mentioned earlier. I've become a member of the Special Committee on Aging and the Labor and Human Resources Committee which handles authorizations for health care.

Oklahoma, incidentally, is well covered in the Senate on this issue because Senator Boren is on the Finance Committee that deals with Medicare and Medicaid. We've covered the bases as far as the Senate is concerned, and I think this hearing will be helpful to me in coming up with ideas on these problems.

Our first panel should come forward, all of them. We have Lewis Farmer, who is the administrator of Wetumka General Hospital; Ron Webb, who is the administrator of Holdenville; and John Nienhuser, administrator of Tahlequah.

Lewis, do you care to be first?

Mr. FARMER. That would be fine.

Senator NICKLES. You might pull that microphone up because we have a lot of people in the back.

## STATEMENT OF LEWIS FARMER, WETUMKA, OK, ADMINISTRATOR, WETUMKA GENERAL HOSPITAL

Mr. FARMER. I'm Lewis Farmer, administrator of Wetumka General Hospital. We are a 34-bed community hospital and at the current time our hospital experiences a 65-percent Medicare patient load, approximately 15 percent in the Medicaid and welfare patient load, making us one of the more highly utilized rural hospitals for the aged population that Senator Nickles referred to a moment ago.

At the present time Hughes County, where Wetumka is located, is experiencing one of the highest unemployment rates in the State of Oklahoma. Therefore, the contribution to indigent care is also one of the more significant roles of our hospital. Well, with 80-percent Medicare-Medicaid, it doesn't leave us very much to make up any cost overruns that the Senator has alluded to.

On July 23, 1984, Wetumka General applied to the Federal Bankruptcy Court under chapter 9 for reorganization. The reason leading up to this particular decision, I think, was twofold, a declining patient census, which the Medicare DRG PRO Program is designed to accomplish.

The second reason is that PPS was implemented without any leadtime or learning curve, if you please. This turned out to be very costly for our hospital because it was one of the early ones to come under PPS. So this I feel was a contributing factor in the decision to apply for reorganization, but those two things, in combination.

Wetumka General Hospital incurred a $1.6 million expansion in 1979. With the declining census and the cash flow situation, they could not meet this debt service. This was the reason for the decision to file the chapter 9 request for reorganization.

Currently the hospital is continuing to operate and is paying its own expenses. However, this situation has caused the hospital to be using its Federal capital pass through costs to meet operating expenses. That means I can't replace my equipment or my facilities. And this is the position that we're currently in.

So our concern, I think, under the program has to do with what is the Federal Government going to do with capital pass through? What are they going to do with the urban and rural differential that the Senator was speaking about a moment ago? With the changing role of the rural hospital, then my hospital falls into what you would classify as a primary care hospital.

And I think one of the great inequities right now is that if I enter into an agreement with a tertiary care center or a secondary care center to handle patients that I cannot handle, the reimbursement mechanism, for a transferred patient is practically nill. If I take a patient in, transfer them to another hospital for services, and they come back to my hospital, as most of you have experienced under the transfer rule, the transferring hospital might as well write it off because there's practically no reimbursement.

So I think that's one of the things that really has to be considered and changed if we're going to continue in the direction that we're going with the changing role of the rural hospital.

Senator NICKLES. Thank you very much. I think I will let all of our panelists make their statements and then I will ask questions of each. Mr. Webb.

## STATEMENT OF RON WEBB, HOLDENVILLE, OK, ADMINISTRATOR, HOLDENVILLE GENERAL HOSPITAL

Mr. WEBB. Thank you. I would like to express my sincere appreciation to you, Senator Nickles, and your Senate Special Committee on Aging for your interest and willingness to listen to the concerns of rural Oklahoma.

I am administrator of Holdenville General Hospital, which is a 49-bed facility that offers primary, rural health care to a community of 5,700 people with a service area of about 20,000 people. Approximately 21 percent of our population is age 65 or over, which is significantly above the State and national average.

As I mentioned, I am from Holdenville General Hospital, a 49-bed facility. Nearly 70 percent of our care is given to Medicare patients. Our hospital receives no tax support for operation, so our solvency depends directly on a fair and appropriate reimbursement for Medicare.

Our patient admissions have fallen dramatically, by 20 percent. We're now averaging only 38-percent occupancy, where 2 years ago we averaged 62-percent occupancy. We think several factors have influenced this drop in admissions.

One is our local economy. As Lewis mentioned, we have a very high unemployment in Hughes County. We had the unfortunate distinction in January of the highest unemployment in the State, of 17.2 percent. Many people cannot afford to enter the hospital and, therefore, do not seek medical care. When they finally do enter, they are sicker and require more costly care.

Second, the prospective pricing system, or PPS, has decreased admissions. Some of the decrease has been good for health care. Some patients in the past were hospitalized admittedly for the convenience of the patients, their families, or the physicians. These patients are now more appropriately being cared for in an outpatient setting.

Last, many elderly are scared and confused over the new Medicare regulations impacting their hospital and physicians themselves. Some patients needing hospitalization are being denied admission because of not fitting the strict guidelines. Patients have called our hospital and literally cried because we tell them that Medicare will not allow their care to be covered. Patients having been hospitalized have been told retroactively by the PRO that their stay was not necessary.

One of our recent elderly patients was hospitalized with congestive clot disease. A few weeks later the patient unfortunately died from the same problem. A week after he died his family received a letter from the PRO that was addressed to the patient to inform him that his hospitalization was unnecessary. This has left the family frustrated and angry and the hospital without any payment for the care given.

All of this has had great financial impact upon Holdenville General Hospital and we feel we responded well to the drop in reimbursements and patients. We have cut our expenses by over 9 percent since last year. Unfortunately, because of pure economics, as our numbers of patients decrease, the cost of providing care to each one goes up.

As a result, and in spite of our efforts to cut the costs, eliminate services, and decrease our level of care, our cost per patient has risen by 7.7 percent. At the same time our reimbursement rate has fallen 6.5 percent per patient. A simple arithmetic shows we've lost substantial ground.

And as I have indicated, we've responded by cutting expenses. We've eliminated one-third of our work force, partially by layoff. And as our county's major employer, this has added significantly to our unemployment rate. We've eliminated ventilator care service for acutely ill patients to cut expenses. This unfortunately requires that more patients be transferred away from their families, causing hardship and expense to them.

The level or quality of care is not the same as before PPS. Our nurses are frustrated because they cannot give 100 percent to their patients as they once did before. Our hospital has taken a severe thrashing since the DRG system was implemented in July of 1984 for us. In over 16 years of existence we have never had a financial loss, due to fair reimbursement and good community support and, hopefully, good management. Even with our layoff and other cuts, we still expect a loss this year of over $150,000.

With such a large percentage of our patients fixed by the Government or in free care, we cannot begin to recoup our losses from price increases. A minor price increase can help recover such a loss to a hospital with 20-percent Medicare, but it's impossible for one with 70-percent Medicare.

We've shifted more care to an outpatient basis to help recoup our losses. Unfortunately the increase this year of $20,000 in outpatient revenue doesn't offset the $1.2 million drop in inpatient revenue.

While the basic premise of PPS we feel is valid, its method of implementation has been grossly inequitable. The rural/urban differential coupled with no allowance for treating large numbers of poor and elderly has created an unfair and potentially fatal burden on our hospital.

We've compared ourselves with another similar-sized facility in the State. Our hospital has 49 beds. The other facility has 54 beds. Our hospitals offer similar services except for two additional ones we offer. Both pay similar salaries, except we pay more for nursing, they pay more for housekeeping and dietary personnel. Many rural hospitals have to pay more than their urban counterparts to entice some of the skilled professionals to live in the rural areas.

As I mentioned before, we treat about 70-percent Medicare. The other hospital averages about 60 percent. Both have similar supply contracts, except in some cases we pay more due to the fact that we're 30 to 40 miles further from Oklahoma City and have higher freight costs.

We're very similar in all aspects except that they fall in the imaginary circle called urban and we do not. And the difference in payment rate is over $900 per patient, and that would mean over $1 million annually for treating the same patients. In other words, we could move our entire hospital, building and all, use the same employees, treat the same patients, and receive $1 million more per year in Medicare payments than we currently do.

So as you can see, the present rural/urban differential is grossly inequitable. The present design will cause even a larger drop in the quality of care in Oklahoma and force the closure of more hospitals. One rural hospital in Oklahoma has closed since January, another announced their intention to close their inpatient facility later this year, a third has held off a summer closure by a sales tax vote last month, and the fourth, which is Wetumka, only 20 miles from Holdenville, has declared bankruptcy.

We think others will follow unless the system adjusts for high numbers of elderly and poor, as Congress authorized Medicare to do, but Medicare officials have chosen not to do.

Senator NICKLES. Say that again.

Mr. WEBB. Congress authorized Medicare to allow additional payments to hospitals with high Medicare and Medicaid loads; however, Medicare has chosen not to act upon that.

In addition, we feel that the urban/rural differential must be more equitable. A final proposal being considered by the administration is to no longer pass through the costs of capital, but to add a small percentage to the DRG rate.

Among the numerous pitfalls in this proposal is our drop in patient volume. Again, simple economics shows that as patient volume falls, the cost of capital per patient rises. An add-on to the per patient reimbursement means that as our cost per patient increases, our reimbursement decreases. This means we will not be able to replace equipment and the facility as it wears out.

If the implementation of the prospective pricing system continues in its present form in conjunction with a freeze and the propos-

al for changes in capital reimbursement, we will face grave consequences. If we continue to offer our range of services at a high level, we feel we cannot last 5 years.

If the intention of the system is to save dollars by closing the rural hospitals and reducing access to care for the rural elderly, I think it's going to work. If the intention is to provide cost-effective quality health care for all elderly Americans regardless of where they live, I think it will fail unless we make some changes.

I plead with you to help our rural elderly and hospitals before quality and services drop even further, or they close. Rural America deserves the same access to quality care as the rest of the country. And with that, if you have any questions.

Senator NICKLES. Thank you very much, Mr. Webb.

John, you might pull that microphone up really close because we do have a lot of people in the back.

## STATEMENT OF JOHN NIENHUSER, TAHLEQUAH, OK, ADMINISTRATOR, TAHLEQUAH CITY HOSPITAL

Mr. NIENHUSER. My name is John Nienhuser. I am the administrator of Tahlequah City Hospital in Tahlequah, OK. There is a crisis situation facing Oklahoma's rural hospitals. It has been projected that 10 to 15 of these hospitals will be forced to close if these problems are not resolved.

The first problem I would like to discuss involves the urban/rural distinction of reimbursement rates under Medicare's prospective payment system. This distinction was made because it was assumed that urban hospitals have a higher labor cost than rural hospitals.

The higher labor cost, if it does exist, is related to providing more intensive specialized care services. The higher relative weight factors for those DRG's which require the specially trained and, therefore, more costly employees already provide a higher reimbursement to those hospitals. The calculation of the case mix index for those hospitals which provide the more complex care also increases the pay they receive.

Table 1 presents a comparative study of the hourly rates paid for selected positions in my hospital and in hospitals of similar size in Oklahoma City and Tulsa.

You can see from the table that Tahlequah City Hospital is never the lowest in any category and is actually the highest in four of the eight included in the study. However, the Medicare Program gives the urban hospitals a wage index that is more than 22 percent higher than mine.

The added revenue rural hospitals would receive if this unfounded penalty were removed could be the deciding factor in allowing a rural community to keep its hospital doors open for the people who depend on it. Ironically, if a rural hospital closes and the next closest hospital is urban, the Medicare Program could well wind up paying more for patient care.

I did a study with two hospitals in Tulsa. One of those hospitals was a teaching hospital. Their reimbursement rate is more than 50 percent higher than mine. And another hospital that is not considered teaching has a rate that is about 11.2 percent higher.

[The table referred to follows:]

TABLE 1.—COMPARATIVE STUDY OF URBAN VS. RURAL SALARIES

| Position | TCH | Urban hospitals | |
|---|---|---|---|
| | | 1 | 2 |
| Staff RN | 8.75 | 9.75 | 8.50 |
| Staff LPN | 6.20 | 6.93 | 6.00 |
| Housekeeper | 4.36 | 4.36 | 3.50 |
| Aides/Orderlies | 4.36 | 4.36 | 3.50 |
| Lab tech MT (ASCP) | 9.33 | 9.75 | 7.25 |
| X-ray tech (ARRT) | 7.82 | 8.67 | 7.25 |
| Physical therapist | 15.54 | [1] | 10.25 |
| Admitting clerk | 5.33 | 5.27 | 3.50 |
| Wage index | 0.8582 | 1.0502 | 1.0386 |

[1] Contract.

The second area I would like to address is physician reimbursement. In Oklahoma, the fiscal intermediary has established five pay zones for payments to physicians. Rural Oklahoma communities, such as Tahlequah, are in the lowest paid zone.

As you already know, several physicians from Tahlequah and I have been working with you and the rest of the members of our congressional delegation to resolve this problem. However, HCFA is still opposing our efforts.

I would like to take this opportunity to reiterate the reasons I feel this change is vitally important to rural Oklahoma hospitals.

First, patients will go out of town for basic medical care if it will have a lower out-of-pocket cost to them. Not only does this take away from the local economy, it also creates an unnecessary hardship on the patients and their families. Also, those patients who cannot get to a physician out of town are not receiving the same benefits as their urban counterparts.

Second, if Medicare patients are going out of town to receive physician care, they will also receive their hospital care out of town. Urban hospitals with their more intensive case mix index cost the Medicare Program more money.

Third, the lower physician reimbursement rates in rural Oklahoma is a serious handicap in recruiting basic specialty physicians which would allow more people to receive needed care in their own community hospital at a lower cost to the Medicare Program.

A quick survey of the administrative board of the local senior citizens identified 4 people out of 20 present who indicated they were using a physician in other areas because of this reimbursement methodology.

All of these factors combine to make this issue very important to Oklahoma's rural hospitals. This could also be a factor which would help determine if a hospital will survive or be among the 10 or 15 Oklahoma hospitals expected to close its doors this year.

The information in table 2 illustrates the importance of recruiting physician specialties to Tahlequah. Tahlequah City Hospital opened on its new site in April 1977. It soon became apparent that the new facilities were attractive to patients and physicians and that additional patient beds would be needed.

Table 2 shows a growth in patient days from 1982 to 1983 and a small drop in 1984. This patient day drop was of no major concern because the number of admissions continued to increase. An expansion project to add 41 beds was completed in November 1984.

Studies by the Oklahoma Health Planning Commission show that Tahlequah City Hospital cares for 72 percent of all Cherokee County residents receiving hospital care in Oklahoma. Other studies indicate that a large part of those people leaving Cherokee County do so due to the reimbursement differential or for some specialty care which could be provided if those physicians could be recruited. The specialties identified as being important to the continued success of Tahlequah City Hospital include orthopedic surgery, pediatrics, and obstetrics-gynecology.

The last two columns of table 2 compare the first 8 months of our last complete fiscal year and the first 8 months of our current fiscal year. This is our reason for alarm, the 25-percent decrease reflected in patient days coupled with a decrease of 22 percent in the number of patient admissions.

[The table referred to follows:]

TABLE 2

| Item | Total year | | | FYTD Feb. 29, 1984 | Feb. 28, 1985 |
|---|---|---|---|---|---|
| | FYE June 30, 1982 | FYE June 30, 1983 | FYE June 30, 1984 | | |
| Pt. day | 17,068 | 17,171 | 15,899 | 10,797 | 8,103 |
| Admissions | 2,926 | 3,148 | 3,285 | 2,240 | 1,738 |
| Ave. Los | 5.83 | 5.45 | 4.84 | 4.82 | 4.66 |
| Monthly Average | | | | | |
| Pt. day | 1,422 | 1,431 | 1,325 | 1,350 | 1,013 |
| Admissions | 244 | 262 | 274 | 280 | 217 |

Although some of the decline can be attributed to the success of the PRO programs, I am convinced that a large part of the decline lies in the fact that many people are now leaving town due to the inequities of the Medicare physician reimbursement that have been previously discussed.

Eliminating the multipay zone for physicians under Medicare would greatly help in resolving both of these problems. I appreciate the support that you and your staff have provided in trying to get this change instituted and would respectfully request your continued effort and support.

Oklahoma hospitals are continuing to work with the Oklahoma Foundation for Peer Review to contain health care costs while continuing to provide quality health care to our patients. There are two areas I would like to see changed to make the program more reasonable and more effective.

First, I think it's inappropriate that the only party which has nothing to gain or lose is the only party that can appeal a denial beyond the first appeal level. If a request for consideration is not decided in favor of the hospital, the physician still gets paid, the patient still receives the care for which he or she cannot be billed, and the hospital gets left holding the bag.

A second change I would like to see implemented has been published in the PRO interim manual instructions by HCFA. This states that PRO's must afford attending physicians an opportunity to discuss proposed denials directly with PRO physician advisors. This quote is taken from the AHA Washington memo of February 15, 1985. Currently, OFPR physician advisors are remaining behind their cloak of anonymity and hospitals and physicians have only the one opportunity for reconsideration of denials.

Another problem hospitals are experiencing, not only with PRO but with HCFA and other regulatory agencies, is the constantly changing environment of regulations and the frequent implementation of new or changed programs before the regulations have ever been written. The retroactive clause of some regulations can have a devastating impact on a hospital's financial condition.

The entire prospective reimbursement system was enacted by Congress and implemented as an experiment on a grand scale. It is obvious that it has created financial problems for many hospitals and even health care problems for some Medicare recipients. Like any experiment, the results will need time to become evident and clear.

Additional problems should be addressed only after the results of the present programs have been determined. I would join with others in urging that what has already been done be allowed to accomplish what it was designed to accomplish.

One factor that has not been discussed is the negative economic impact that closing a hospital can have on a rural community. Hospitals are a business and in most rural communities are one of the major employers.

If these hospitals do not receive adequate reimbursement for the services they provide, including services to Medicare patients, and are forced to close their doors, the resultant unemployment and welfare expenses to the Government could well be greater than having provided adequate reimbursement to begin with.

Thank you for this opportunity to testify on behalf of rural hospitals and for the efforts you and your staff have exerted to help bring equity to the reimbursement system.

Senator NICKLES. Thank you very much for your statement. And to all of our panelists, I appreciate your comments.

To bring you up to date on where we are in our battle with HCFA in getting a unified rate for reimbursement for physicians. As you mentioned in your statement, we have five reimbursement zones for physicians in the State of Oklahoma. We have been trying with HCFA for the last 2½ years to get a unified rate for the State of Oklahoma.

The State of Arkansas does have a unified rate. We have physicians throughout the State of Oklahoma that have grievances about this. OMA has come out strongly in favor of a single zone. The Oklahoma Legislature and the entire Oklahoma congressional delegation are also supportive of the unified rate.

For those in the audience that maybe aren't quite as familiar with this issue, we've contacted HCFA and said that we would like to have our Oklahoma physicians be paid on the same scale, so that a physician in Tahlequah would be reimbursed the same for

an office call as a physician in Oklahoma City, Tulsa, Enid, or any other place.

John, do you happen to know what physician reimbursement is for an office call in Tahlequah, and what it might be in Tulsa?

Mr. NIENHUSER. The Medicare reimbursement—the dollar the physician receives for Medicare, they tell me, is $9.60.

Senator NICKLES. In Tahlequah?

Mr. NIENHUSER. In Tahlequah. In Tulsa, around $18 for the same.

Senator NICKLES. I'm not sure it's quite that high, but there are some substantial differences, and we might get that on the record. We've wrestled with that.

In trying to get this from HCFA, we were denied once. We then contacted HCFA again and they said the reason or the primary reason for the first denial on a unified rate was that it would cost more money. According to the report which they gave me—which is very thick and full of bureaucratic nonsense—was that it would cost 5 percent more.

My response was, "Come up with a unified rate and have it be cost neutral." Certainly that could be done, other States, as I mentioned, like Arkansas, have done it.

Their response was another denial, with somewhat of a caveat. Although they denied it again by putting the burden back on Congress in saying that the law required reimbursement would be on an area basis instead of on a State basis.

I feel like it's a reluctance on their part to want to try it. It's a change. It would require some work to get it changed. But they did leave the option open for Oklahoma to be a pilot State to try changes in reimbursement in physician payments, and one of the changes that I would like to see would be a unified rate.

And so it may well be that we will be able to go through to this change on a trial basis. And, if it works as well as I think it will, it will eliminate a lot of the discrepancies that we have and make it simpler to administer.

And we even have cases where physicians practice in two areas, and for office calls in this area, they're reimbursed at a much higher rate than they are for an office call in another town. So we will pursue that and hopefully we will be successful.

To all of our panelists, I might ask you a question. All of you mentioned that the prospective payment system has caused some hardship. The PPS is a movement away from a cost-plus system, which was turning out to be enormously expensive.

John, I heard you say that we need to stop for awhile and let PPS work before you make additional changes. A little more critical were Mr. Farmer and Mr. Webb on PPS. Do you think that the concept is totally wrong or that it was just enacted very quickly and is particularly punitive in the rural areas?

Mr. FARMER. I think the concept is very viable. In fact, I prefer this method over the old cost-based method. If I can maintain the patient load, I can operate under PPS.

Mr. WEBB. I would agree with Lewis. I think the concept is very viable and in theory it's a very workable system, but it's just that, again, it was implemented so quickly and that the rates are not

structured fairly for reimbursement for the rural hospitals. But the theory behind the system is a good theory.

Senator NICKLES. Mr. Webb, you mentioned in Holdenville the discrepancy on the urban/rural costs your hospital about $1 million?

Mr. WEBB. Compared with another similar hospital that had the urban rate for the same type of patients, it was worth $1 million.

Senator NICKLES. That big of a difference? Because, you know, when I mentioned the difference on pneumonia between two communities that aren't that far apart and the one in the rural area is half of what the urban area hospital was getting, and you said that your average was $900 per patient difference.

Mr. WEBB. Correct.

Senator NICKLES. And then in a year's caseload, you are talking about $1 million. Would that keep you in the black and keep you in business?

Mr. WEBB. Very much so.

Senator NICKLES. You're losing right now $150,000?

Mr. WEBB. Yes; $150,000 for this year. And as the rural rate is totally phased in to a national rate, we expect that loss to grow each year over the next 3 years.

Senator NICKLES. This is one of the problems that I'm having right now. As many people probably know in this room, I'm one that feels like we need to cut spending in every area, including health care.

One of the problems that I see is with the regulations that freeze reimbursement rates, which we will probably see this year. In DRG's, I think most people were expecting a 3½-percent increase. But, when we freeze rates, we are going to be freezing in the inequities, and so the inequity and the inequality between rural and urban continues.

What I hear you saying, Ron, is that you could probably live somewhere in between if we could make some adjustments in the allocation formula.

Mr. WEBB. We're not asking, obviously, for the exact same level or be up to the $1 million difference, but if there is a freeze, if the total dollars for Medicare could be frozen and then adjustments could be made within to make it more equitable, I think it would work easier and still accomplish the same purpose on a national level.

Senator NICKLES. Could you say again—I think all three of you at one time or another had mentioned the passthrough, as far as capital costs, and you are actually using capital costs and you're passing that through, I guess, and using that for operations?

Mr. FARMER. Yes; right now the capital passthrough cost, particularly for depreciation and the interest expense, is quite high for Wetumka General Hospital. However, even with that, we were not able to maintain the debt service.

Senator NICKLES. So you've taken not chapter 11, chapter 9?

Mr. FARMER. Chapter 9 is reorganization.

Senator NICKLES. So you have reorganized and you are still operating?

Mr. FARMER. We're in the process of doing that. We're operating under the guides of the court at this time and preparing a plan.

Senator NICKLES. You are not servicing your debt load, so how is that going to be resolved? You have some bonds or something you are supposed to be paying some interest on that you haven't made payments?

Mr. FARMER. Sinking fund payments are suspended. The court has asked us to draft a plan to present to the court with what we can do toward our present debt service with our existing cash level. This will be contingent on what Medicare does with capital pass-through reimbursement.

Senator NICKLES. Are you optimistic that something will be worked out and the hospital can continue?

Mr. FARMER. Yes, very optimistic. In fact, the hospital has been operating since July 1984, and been able to maintain its own expense level and meet its payroll and I think that is very positive for the court to consider.

Senator NICKLES. So you actually have a positive cash-flow in operations but not in debt service?

Mr. FARMER. Yes.

Senator NICKLES. Now, Wetumka is how far from Holdenville?

Mr. FARMER. About 20 miles.

Senator NICKLES. You also have Seminole with a hospital, a larger hospital. How far is Seminole?

Mr. WEBB. It's about 20 miles from us. We're halfway between Seminole and Wetumka.

Senator NICKLES. Is it a case where, as some might say, you've got too many hospitals in too small of a geographical area?

Mr. WEBB. That's possible. Back several years ago I don't think that was the case, but now with the drop of patients, we may need fewer hospital beds in the area. Again, as any community loses their hospital, the economic effect to that community is devastating.

Senator NICKLES. Is there any discussions among the area hospitals of trying to pool resources and maybe do some type of a—you handle this and we'll handle this, and maybe be able to cut some expenses or operation's overhead, combine administrative levels, or——

Mr. WEBB. Very much so. And we've had talks over the last 2 or 3 years of combining into one hospital eventually. We've shared some services. We've shared some nursing services in the past. And we're obviously having to do more, which is good, have fewer resources and allows us to accomplish the same thing. But we cannot do it quick enough to respond to the drop in our patients.

Senator NICKLES. How many patients—or I will ask all of our panelists. What percent of occupancy do you have today?

Mr. FARMER. Approximately 30 percent.

Senator NICKLES. Thirty percent. So how many people do you have in your hospital?

Mr. FARMER. As of this morning I had seven.

Senator NICKLES. Seven people in the hospital?

Mr. FARMER. Yes, sir.

Senator NICKLES. And you have a debt load of how much, Mr. Farmer?

Mr. FARMER. Approximately $15,000 per month.

Senator NICKLES. So that makes it hard to stretch. So you have had how much on an average? Is that low or high?

Mr. FARMER. That's about average at the present time. For the month of February we averaged 9.9 patients per day.

Senator NICKLES. So the last month you averaged 9.9 out of a 34-bed——

Mr. FARMER. Thirty-four-bed, yes, sir.

Senator NICKLES. Three years ago were you averaging 20 or higher?

Mr. FARMER. We were putting patients in the hall 3 years ago.

Senator NICKLES. And mostly because of the prospective payment system? Is that the gist of it? Was it somewhat operating as a skilled nursing facility?

Mr. FARMER. I think the other contributing factor at Wetumka has been the ability to attract physicians. And this physician differential that John was alluding to a moment ago I think was a contributing factor. Because we did lose to an automobile accident one of our major attending physicians and we've had recruiting difficulties since that time.

Senator NICKLES. How many physicians do you have in the hospital?

Mr. FARMER. I have one-and-a-half physicians at the present time. Dr. Fraley splits his time between Seminole and Wetumka.

Senator NICKLES. How is Holdenville doing?

Mr. WEBB. We're averaging 38 percent on the year, which is approximately 18 patients, which is what we had in today. Last March was our—March of 1984 was our second biggest month in the history of the hospital. This March was our second lowest in the history of the hospital. So the turnaround has been that drastic.

Senator NICKLES. What about Tahlequah?

Mr. NIENHUSER. It depends on if you want to count 58 beds or 99 beds. I have 99 licensed but I am only operating on about a 43-bed level. We had 31 patients in the hospital yesterday morning.

We're looking at alternative uses of some of the other beds, mental health programs, subsidy programs, and trying to look at a special program to get an exemption from the swing beds. I'm over the 50-bed limit on the swing beds and I am trying to get a special exemption so I can utilize swing beds and provide some skilled nursing beds in the community.

Senator NICKLES. How difficult is it to get that through? How long does it take?

Mr. NIENHUSER. I could probably go through a CON process and get designated skilled nursing beds in the hospital. The only difficulty or concern I have with that is, No. 1, it's a permanent situation. If I wanted to recover those beds as acute care beds, if I do attract those specialty physicians, as I discussed in my testimony, then I would have to go back through recertification process on acute care.

I've been working through a special program called negotiated investor strategies, which involves various levels of government to develop special demonstration projects, and this is one of the areas which we are trying to investigate. And if I could get that demon-

stration allowance, then I would have a greater flexibility on what I could do with these beds.

Also, the CON process would require a licensed nursing home administrator be hired. That is hard to justify for a 6- to 10 bed unit.

Senator NICKLES. Do you think the State of Oklahoma needs a certificate-of-need process?

Mr. NIENHUSER. I haven't had any problems in working with the CON process from the projects that I have been involved with, and I think they have done some good. I think perhaps there needs to be some areas addressed on what things should be included under the CON.

Senator NICKLES. Any comments on that?

Mr. FARMER. I currently have a CON pending before the Health Planning Commission to convert 13 of my 34 beds to swing bed status for Wetumka.

Senator NICKLES. How long has that request been pending?

Mr. FARMER. It was submitted at the end of March. I expect it to be on the docket in the month of June.

Senator NICKLES. So you are not upset about how long it's taken?

Mr. FARMER. Well, I would like to have had it a little sooner, but I missed the deadline in submitting the application to be on in May so June is the best I can hope for.

Senator NICKLES. Are you expecting to be successful in your application?

Mr. FARMER. Yes, I am.

Senator NICKLES. Any other comments from any of our panelists?

John, I might ask you one quick question. You had basically two or three comments. One related to the PRO and the statement that was made by some instructions that came from HCFA. It said that PRO's must afford attending physicians an opportunity to discuss proposed denials directly with PRO physician advisers.

Mr. NIENHUSER. Yes.

Senator NICKLES. Are you stating by that, that presently that's not the case?

Mr. NIENHUSER. No, it is not being done. The physician advisers are totally anonymous and issue their letter of denial prior to discussions with the attending physician.

Senator NICKLES. And you're saying it's not supposed to be that way?

Mr. NIENHUSER. Well, according to the instructions that did come out and were printed in the Washington letter, the physicians are supposed to be given an opportunity to talk directly with the physician advisor prior to a denial being issued.

Senator NICKLES. Are you having a large number of denials in any of the hospitals?

Mr. NIENHUSER. I haven't really had that many. Probably in the 6 months that they've been doing the survey, we may have had seven or eight total.

Senator NICKLES. They're not surveying 100 percent of the cases. What percent are they surveying?

Mr. NIENHUSER. I really don't know what their percentages are.

Senator NICKLES. Mr. Webb, you mentioned what I would call a very bad case where they made a denial and the patient died shortly thereafter.

Mr. WEBB. Yes.

Senator NICKLES. Was the denial reversed?

Mr. WEBB. We've appealed and have not heard back from the appeal. We've had approximately six denials already and we've appealed all of them and none of them have been overturned yet.

Senator NICKLES. None of the denials have been overturned yet?

Mr. WEBB. No.

Senator NICKLES. Is there still the animosity from the physicians throughout the State on the PRO concept as there was a few months ago when I had my original hearing?

Mr. WEBB. It is in Holdenville.

Mr. NIENHUSER. I think it's decreasing somewhat but there is still some animosity there.

Senator NICKLES. Gentlemen, we appreciate very much your statements before the committee, and I look forward to working with you in the future. Hopefully we will have some success, at least in the urban/rural discrepancies. And I appreciate you being with the committee today.

Mr. FARMER. Thank you.

Mr. WEBB. Thank you.

Mr. NIENHUSER. Thank you.

Senator NICKLES. On our next panel we have John Neal, who is administrator of Pawnee Municipal Hospital; Jerry Hulin, executive vice president of Innovative Health Programs, representing eight rural hospitals; and Greg Guntly from St. Joseph Regional Medical Center in Ponca City.

I don't know that it makes any difference. John, do you want to be first? Pull that microphone right over and get it right in front of you.

## STATEMENT OF JOHN NEAL, PAWNEE, OK, ADMINISTRATOR, PAWNEE MUNICIPAL HOSPITAL

Mr. NEAL. Senator, I am not going to take up much time to repeat what you have already heard this morning. Pawnee Municipal Hospital is a 40-bed rural hospital experiencing the same problems you have already heard in the other rural hospitals of our area.

In sitting back and listening to the comments this morning, which I totally agree with the comments made this morning, I wanted to shorten my time and speak specifically for the elderly care and what we've experienced in Pawnee.

Pawnee took a very positive approach to the prospective payment system in developing our DRG management program at Pawnee. I think a big success to our program has been the support of our physicians in trying to understand the system and work with the hospital in order to maximize on reimbursement of every patient that we have.

Pawnee has experienced a 30-percent decrease comparative to last year. In the last 3 months, though, we have seen a 10- to 12-percent increase in our patient load, which presents some of the problems, as stated also, in the equality of payment to the rural hospitals.

We have maintained a cost and developed a cost case at our hospital in order to obtain the results that the overall program is trying to capture in holding down the cost and benefit to the hospital for those hospitals that are reaching those goals. But in the last few months we have seen an increase in the patient load of the elderly care that are sicker, requiring more care, and is driving up our increased costs.

The main concern I want to speak right now on is the elderly care. We have seen—we have families come into my office, visiting with the physicians, and others, that are concerned with the discharge criteria and early discharges. We're trying to prevent this, but I don't know for how much longer our hospital and other rural hospitals can maintain trying to comply with regulations based on the cost, with increased cost that we're seeing.

Right now we can survive on a month-to-month basis, but in your planning and development for the future, with the increase of the over-age-65 population which we have in the Pawnee area and typical of Oklahoma, it's my concern of how much longer can rural hospitals maintain this and provide a future for the elderly.

We are in the business to run it as a business but also provide care for the future. This is where I feel like we should look toward our problems for the future and not looking at what we've done in the last year and is it acceptable now. Is it going to be acceptable 6 months or a year from now? At Pawnee I think it's very questionable. I just don't know how to answer that right now.

So I will not go on any further. The statements you have heard this morning, Pawnee is experiencing these same problems.

Senator NICKLES. Thank you very much, Mr. Neal. Mr. Hulin.

**STATEMENT OF JERRY HULIN, OKLAHOMA CITY, OK, EXECUTIVE VICE PRESIDENT, INNOVATIVE HEALTH PROGRAMS**

Mr. HULIN. Thank you, Senator Nickles. It's indeed a pleasure to be invited to present testimony today.

IHP Corp. and Presbyterian Hospital manage and lease eight hospitals across the State of Oklahoma ranging in bed size from 19 to 90. We provide 139 services to 50 hospitals in 5 States. We are Oklahoma's largest health care provider. In Oklahoma we are in a unique position to see and be a part of the health care in eight rural communities.

I am here today to share some concerns with you and some considerations. What's the future of health care within those communities? What has been done or can be done to alleviate those concerns? Provide some suggestions for consideration to enhance the rural hospital. And, what are the potential effects on a community with no readily accessible hospital care system?

I will identify some primary concerns and considerations and then address in more detail each of those. They are as follows: Inpatient census has decreased. There are inequities in rural reimbursement as compared to urban. There is a proportionately greater number of Medicare recipients in rural communities. Indigent care is increasing in rural communities and Oklahoma Medicaid has initiated a capitated reimbursement program. Insurance companies, industries, and the private payor are less willing to subsi-

dize health care for Medicaid and/or Medicare patients and for bad debts. The economy of the rural community is depressed. Rural hospitals either have not or have not been able to fund adequately for depreciation.

Two years ago many rural hospitals experienced 80-percent occupancy rates. The occupancy rates were noted to drastically reduce with the advent of the prospective payment system. We have seen decreased lengths of stay, earlier dismissal of the patients from the hospital, and in many instances, fewer admissions to the hospitals. The combination has resulted in occupancy rates of 30 to 40 percent in many rural hospitals today.

Although that same group of hospitals may be receiving a greater percentage of their charges, in fact, as much as 100 percent in some cases, that was less than under the retrospective payment system. The charges are considerably less and, thus, cash flow to those hospitals is less. I would submit that any hospital that experienced a 40- to 50-percent decrease in volume would, No. 1, be forced to decrease expenses, and, No. 2, reconsider the products and services it offers.

The inequities in reimbursement between rural hospitals and urban hospitals are perhaps the greatest economic plight suffered by the rural hospital. A study done in Oklahoma compared 12 admitting common diagnoses to both urban and rural hospitals. The study determined that the reimbursement to rural hospitals averaged 36 percent less than to the hospitals for the same procedures.

In an actual case, a rural hospital received $2,959 as compared to $4,802 received by its urban counterpart for the same gallbladder removal procedure.

One mechanism used to determine prospective payments to individual hospitals was history. Prior costs influence the payments made today. Therefore, the rural hospital that kept its costs low during the retrospective reimbursement days suffers today for some of the efficiencies demonstrated in the early 1980's.

In calculating the payments made to rural hospitals, the Government also assumed that labor costs were less in rural hospitals. Enticing well-qualified health care professionals to rural areas has not been easy nor inexpensive. We all comply with wage and hour laws and the minimum wage threshold is used to determine the salaries of many nonlicensed or nonregistered health care employees in both rural and urban areas. Therefore, I do not believe the assumption made by the Government that labor is less expensive in rural areas is valid.

To compound the problems of decreased census and reimbursement inequities is the percentage of 65-and-over population in Oklahoma. Many of the 65-and-over age group have chronic illnesses which require repeated hospitalizations. Cost shifting, which has commonly occurred in hospitals, is not as workable when there are less than other patients to subsidize the Medicare beneficiaries whose charges may not be paid in full.

Another concern of the health care industry is the issue of indigent care. The 1980 statistics indicate that 26.2 percent of the rural Oklahoma population exists at or below the poverty level. Bad debts in some rural hospitals have reached 11 percent of the total accounts receivable.

While there is an obligation and a desire on the parts of the hospitals to deliver some charity care, we must remain profitable in order to be charitable. I submit that it would be difficult for any business to remain viable if 11 percent of their products or services were not reimbursed.

The Oklahoma Medicaid Program has also made drastic cuts which have affected all hospitals. Hospitals are paid on a per diem basis up to 10 days. If a patient requires further hospitalization, it must be considered charity care.

We are also faced with a lack of cash reserves with which to maintain our hospitals' physical plants. Many rural hospitals in Oklahoma were built with Hill Burton funds some 15 to 20 years ago. Because of cash flow problems these hospitals have not been able to fund for depreciation or may have borrowed against the fund for hospital operations during difficult economic times and have never recovered to the point of replacing the reserve.

What happens to a hospital when the plant is no longer functional, the hospital bond market is unpopular, and there are not enough assets against which to borrow—not to mention the risk of the lending institution. In fact, what happens to a community when this happens to a hospital, and what happens to a State when this happens to several communities? Food for thought, no doubt.

As hospitals, particularly rural hospitals, we have a commitment to provide health care of the highest quality possible and IHP, as a management company, shares that commitment with the community in which it serves. We have attempted to be creative and foresighted in regard to hospital management.

We have done many things in conjunction with hospitals to help protect not only their viability but their successful viability. We utilize group purchasing systems throughout the entire system. We encourage hospitals to obtain computerized programs to maximize reimbursement in their prospective payment system.

Four VA hospitals in the group are participating in a swing bed program, which enables the patient to receive an appropriate level of care without a tremendous financial drain on the hospital. We have encouraged the medical staffs of the hospitals to utilize outpatient services whenever possible even though the financial incentives to do so are skewed because outpatient reimbursement is still based on the retrospective payment system.

We have decreased the staff in the hospitals to accommodate the lower census levels. We have conducted energy audits. We have prudently shopped for insurance of all kinds. We have frozen employee salaries and benefits in some hospitals to control costs. We have in some cases voluntarily disbanded Joint Commission Accreditation of Hospitals and seeked Medicare certification to control costs.

We have stepped up collection efforts in hospitals and have seen benefits. We have sought the support of the people via a sales tax election in one county and found the people wanted a hospital. The vote was a resounding yes. The tax question passed with a margin of two to one.

We have not been stagnant in the search for cost containment and creative management but also we need the ear of an interested

and objective government. We do a business called primary care very well in rural communities; 65 percent of the health care delivered to Americans is primary care.

As rural hospitals we do not wish to compete with either secondary or tertiary care centers, but we would like to do what we and we alone can do best and most financially efficient. We have a viable place in the health care market and to the rural communities.

What happens to a community when there is no longer an accessible health care delivery system? We are thankful we do not have enough experience to have all the answers. Perhaps young families would be unlikely to choose a community without a hospital.

Retail businesses would surely suffer if a payroll of $1 million or more were removed from a community. Less tax dollars would be available to support already faltering school systems. Land values and mill levies would likely decrease.

The real challenge is to define those things that reasonably would assist communities in maintaining their hospitals. I believe that the development of a more equitable urban to rural reimbursement program would be a good start.

Prospective reimbursement for outpatient services could encourage the use of outpatient treatment. Capitation of malpractice settlements could help retard the increasing cost of professional liability insurance. Adequate notice to hospitals regarding changes in regulations would allow hospitals time to prepare for change.

These are just a few of many productive suggestions that have been made to reduce the plight of rural hospitals. We have met and considered challenges as opportunities in the past and will do so in the future.

We recognize the problems of paying for health care and are willing to put forth efforts to contain costs. I do not believe the prospective payment system signals the end of rural hospitals, but there needs to be modifications in the system in order that we all may benefit, especially the patient in need of health care.

I believe the communities need health care and the health care delivery system needs the community which supports it. I believe the State of Oklahoma, with a population of 3 million, also needs primary care hospitals to serve its people just as much as Chicago or New York, with populations of 6 million and 8 million respectively, need primary care hospital beds.

On second thought, even more so, because the people of Oklahoma are spread over 69,000 square miles and I believe the people of Oklahoma have a right to access health care when they need it. Thank you.

Senator NICKLES. Thank you very much, Mr. Hulin. Our next panelist is Greg Guntly, president, St. Joseph Regional Medical Center, Ponca City.

## STATEMENT OF GREG GUNTLY, PONCA CITY, OK, PRESIDENT, ST. JOSEPH REGIONAL MEDICAL CENTER

Mr. GUNTLY. Much of what has been said today I am in agreement with. I want to present today, however, an alternative that we have proposed for the area of Oklahoma where we reside and

present the scenario that led up to that and then discuss a few of the things which may—I consider myths which have been mentioned this morning.

First of all, on March 6, 1985, the board of trustees of the St. Joseph's Regional Medical Center took a step to consolidate and reorganize services at the campuses of Blackwell and Ponca City. The medical center has two campuses, a 64-bed campus in Blackwell, OK, and actually a 203-bed campus in Ponca City, and the distance between them is about 20 miles.

The three-pronged objective was to discontinue acute inpatient care at Blackwell and Ponca City campus. No. 2, was to develop the Blackwell campus as an outpatient facility. No. 3, was to develop a comprehensive marketing plan for both campuses to insure that overall health care needs of the service area are met.

In the past 18 months, the health care industry of Oklahoma has watched two rural hospitals file for bankruptcy and one close due to the insufficient utilization and funding. It is a matter of record that numerous others are in critical financial condition, indicative of the fact that the days of hospital growth and expansion as we knew them have come to an end.

Current trends in government and private health care reimbursements penalize all but the most critical of hospital admissions. In an effort to reduce costs, emphasis is placed on outpatient care and the popular PPO's and HMO's create a remunerative disincentive for inpatient utilization. Health maintenance and quick repair are the current fashion in health care.

St. Joseph Regional Medical Center, as virtually every other acute inpatient care facility in the State, has fallen victim to the change. The Blackwell campus, the 64-bed facility, has declined in average census by approximately 17 percentage points in the past 3 years.

In a serious effort to prevent such decline, three physicians had been recruited in the community in 1981. Within 2 years, they had gone, leaving behind office space and subsidized practices offered to lure their continued stay.

It is evident that rural hospitals which exist in the small rural community settings do not have the amenities and promise that lure physicians to the metropolitan areas. In fact, one-third of Oklahoma hospitals are not accredited by the Joint Commission of Accreditation of Hospitals, which is considered the "sterling" of hospital care.

The Blackwell campus, built in 1955, is fully depreciated and continues to operate in a financially stable environment due only to the fact that minimum has been invested in the modernization of the physical plant. Meeting modern hospital standards would necessitate expensive renovations, which cannot be justified by declining utilization trends.

In a proactive stance, the board of trustees directed a detailed study be conducted of the area demography, patient utilization patterns, and physician practice patterns and identification of existing health care services within the area. Information was necessary to gain direction and set a course of appropriate action in response to the staggering changes in the industry.

With change eminent and nature of change so uncertain, Oklahoma rural hospitals find themselves at a loss of direction and most have elected to take a wait-and-see stance or beg the Federal Government to help. It is apparent that no more money is forthcoming from the Federal Government.

With a mission to continue provision of quality health care in the community of Blackwell, the Sisters of St. Joseph and the board of trustees elected to accept the recommendation to consolidate, a rational conclusion of the detailed service area study. The plan was to be placed in effect before resources had dwindled and before the financial environment was unstable.

Pundits of the health care industry in the past 4 years have predicted the necessity of consolidation and phasedown of inpatient acute care as the only viable alternative for maintaining quality and affordable health care in the small rural communities.

The decision made for the Blackwell campus is indeed on the cutting edge of health care policy. It is an innovative and courageous move made by the Sisters of St. Joseph and the board of trustees to create a composite of health care for Kay County in Oklahoma and those counties that surround it in Oklahoma and Kansas.

The acute outpatient facility with a full range of related services at the Blackwell campus will complement the acute inpatient services and programs to the Ponca City campus 18 miles to the south. The hospital in Blackwell is not closing. Inpatient care is being discontinued. In its place a complement of services will be developed which will more effectively meet the needs of the community.

These include a 24-hour emergency room, physical therapy, radiology, laboratory, home care, and cardiopulmonary services. The efforts made in Blackwell may be a model to other communities who have a burden to provide quality and affordable health care in an environment of diminishing health resources. There are some myths which I have heard here; I believe they're myths, and I would like to share my opinion about them.

The myth that recruiting MD's to the small community cannot be done without a hospital is incorrect. A small inadequately staffed, nonaccredited institution makes it difficult to recruit physicians to a community. Recruiting industry to a community cannot be accomplished without a hospital. I believe that industry no longer wishes to support hospitals.

And I think that's evidenced by the coalitions that have been developed in such places as Tulsa, so that industries may be more attracted to a small community if there is no hospital than one with a hospital that is in difficulty. I think the fears of availability of care is one of the major problems with the smaller communities, because people think hospitals are security.

It is my belief that better emergency care can be provided for much more economical amounts of money in smaller communities if they close inpatient facilities which may be duplicative. I think there's a myth that care is care no matter where it's received, and I think we've talked about that, that an appendectomy somewhere is the same as an appendectomy somewhere else.

I think that is not true. There are significant differences in care in hospitals within our State, within every State. Not that a rural hospital is not first class; it may be. But the fact that one-third of

the hospitals in our State are not accredited causes me to question the commitment to quality on the part of those hospitals.

I think there are some obstacles to change that we're facing, and I think that some of them are the planning legislation which still exists in Oklahoma which is restrictive. It's a barrier. It's a delay mechanism. Even though everybody sitting here said they're going to get approval, they've still got to wait until it goes through the bureaucratic process, and plus we've got to help pay for it to support this bureaucracy.

They now make us pay in advance so that they can continue to support the burdens of this organization. I think that's an obstacle to change. Community awareness of changes in health care is critical and many of our communities are not aware of the drastic need for change and the drastic changes that are occurring in the rest of the United States.

In some communities the local media does not even bother to print information about hospitals that go broke in Oklahoma. They print the other side, only one side. It's unfortunate that the information is not as available to people as it should be. I think the State licensing laws which are being looked at are an obstacle to creating new facilities such as the one that we're proposing for Blackwell.

The reimbursement and incentives for establishment of community health care centers without beds—there are none—so that in our situation, we have a viable institution that would remain as an inpatient facility which would help support this community institution without beds. But there are no current reimbursement methods to support such an institution, and I think that needs to be looked at. Thank you.

Senator NICKLES. No current method to support another institution. Do you mean strictly on an outpatient basis?

Mr. GUNTLY. Yes. The reimbursement methods are set up to support hospitals. They're not set up to support these other kinds of facilities. They could be done, I guess, but there's no incentive to create these——

Senator NICKLES. That is interesting. A couple of questions for all of our panelists.

Mr. Neal, you are also working as executive director of Shared Alliance, is that correct?

Mr. NEAL. That's right.

Senator NICKLES. Could you pull the microphone over and explain what you are doing in the Pawnee area with several county hospitals.

Mr. NEAL. We have formed back in December a group of hospitals, six hospitals in the Pawnee area, that we entered into the idea that hospitals could share services, not in a legal or a financial binding agreement. We have total economy within our hospital, individuality of our hospital, but as a method to share services where available, to look at our cost, to how we can reduce costs by group purchases.

And I am sorry, at this time I would like to be able to give you some results but only being 3 or 4 months, I would be a little premature in giving you results of our alliance, but we do see it as an

attempt to see how rural hospitals can work together and develop programs for the future.

Senator NICKLES. You are actually working with Fairfax, Hominy, Cushing, Drumright, and Stroud?

Mr. NEAL. That's correct.

Senator NICKLES. In addition to Pawnee?

Mr. NEAL. That's correct.

Senator NICKLES. All of those are hospitals in, what, the 20- to 40-bed range?

Mr. NEAL. That's correct, except for Cushing.

Senator NICKLES. And Cushing is a little larger?

Mr. NEAL. Yes, sir.

Senator NICKLES. They, I'm assuming, are experiencing some of the same dilemma that a lot of the rural hospitals are as far as financial obligations and so on?

Mr. NEAL. I would say all of the hospitals within our alliance are suffering the same situation. We have a couple of hospitals that are under metro rate. The other hospitals are under rural rate. We're all discussing that, of course.

But with a community, the size of the community, the increase of elderly care, the concern for delinquent services versus increasing costs and competition of the hourly wage for the caliber of people that we need to recruit to the rural care areas, and this winter bringing on longer term sicknesses compared to what we had planned for, increasing all of our costs.

So it is important. Instead of going to the new revenue source or increased revenue services, it's looking at what we have for primary care in order to save or reduce cost or share cost.

Senator NICKLES. Are you sharing physicians? Are you sharing skilled personnel?

Mr. NEAL. We have already developed between another hospital—Fairfax Hospital and Pawnee Hospital have entered into a trial program on surgery labor alliance, we call it. It's sharing personnel in the labor of surgery care. We are looking or working with Cushing Hospital on reduced costs for CT scan procedures in this area.

Senator NICKLES. Mr. Hulin, I appreciate your statement. You were talking about some things that we might be able to do and mentioned a more equitable return for urban and rural reimbursement.

You mentioned prospective reimbursement for outpatient services could encourage outpatient treatment. Right now, there's no prospective payment period for outpatient? That's all done on cost basis?

Mr. HULIN. It's all done on a retrospective system, yes. The Government essentially encourages us to take patients outside of the institution and to provide the services on an outpatient basis, and yet they have not allowed for the prospective system to really encourage the use of that.

Senator NICKLES. Well, do you favor moving to a prospective payment system as well for outpatients?

Mr. HULIN. Most definitely.

Senator NICKLES. Do you think that would help hospitals, patients, and taxpayers?

Mr. HULIN. Yes; I think it would benefit everyone. I'm not sure that at this point in time in a lot of the rural communities it's going to be enough help to really solve the problems though, but I think that anything we get certainly is an added incentive to be able to provide the care in these communities.

Senator NICKLES. Would you be able to define the cases and put everybody in these classifications?

Mr. HULIN. We were able to do it from the inpatient side, so I assume we could from the outpatient.

Senator NICKLES. You actually manage eight rural hospitals?

Mr. HULIN. Yes, sir.

Senator NICKLES. In the State of Oklahoma, and that's under Presbyterian Hospital?

Mr. HULIN. Yes, it is.

Senator NICKLES. Is that under Presbyterian or under Health Care Corp., HCA?

Mr. HULIN. We are in the process of being acquired by Hospital Corp. of America. We have the certificate of need in place and that sort of thing. That will probably not be consummated for another 90 days.

Senator NICKLES. When that is consummated, is there any thoughts on what will happen to the administration that you're doing on the other hospitals? Will that be included in the package?

Mr. HULIN. We assume that most all the hospitals—or all the hospitals we're currently working with—will make a transition along with us to the Hospital Corp. of America.

Senator NICKLES. The Hospital Corp. of America being somewhat different in the fact that it's a for-profit organization?

Mr. HULIN. It is a for-profit organization, yes, a stockholder organization.

Senator NICKLES. The hospitals that you are administering are now nonprofit?

Mr. HULIN. Basically we provide contract management. It has no—IHP Corp. is a for-profit subsidiary of Presbyterian Hospital at this time, so it really will have no impact upon any of those currently managed hospitals.

Senator NICKLES. You are providing management services for these hospitals, and you mentioned several things that you are doing in trying to help them—anywhere from some computer services and other management services to trying to help them in administration. Have you been successful? Have you been able to take over hospitals, say, rural hospitals that financially have been on the ropes and keep them in a positive cash flow situation?

Mr. HULIN. No; I think there are benefits obviously, we believe, in a management system, but Wetumka is a prime example of not being really able to do much with a hospital, and there was just very little to work with when we started there. We happened to be in a position of managing the Wetumka Hospital.

Senator NICKLES. Excuse me just a second. Could you answer that again?

Mr. HULIN. Yes. I think at some instances we have certainly been able to improve the efficiencies of operation of a hospital, but in some cases it's just a situation that's virtually impossible, in that we do manage the Wetumka General Hospital that's in the

process of going through the reorganization. So there's been very little to work with in that community, and as the census has declined, the debt load is just insurmountable, and it's virtually an impossible task.

Senator NICKLES. In a case where the patient population is so low, it's very difficult to be able to handle the debt load?

Mr. HULIN. In addition, the population within the community itself is extremely low and has declined in the past years.

Senator NICKLES. You also mentioned one other thing, and I think I've heard this from several people. I haven't commented on the adequate notice to the hospitals regarding changes in regulations, therefore, to allow hospitals to have time to prepare for those changes.

I echo that and I can sympathize with all of you that are in this field as you see these changes that have come about just in the last few years since I've been in the Senate. Then to look at some of the changes that we're looking at now, they are substantial and an entirely different payment system and approach. I can easily see how it could make a lot of difference, not just on the hospitals, but on the communities and certainly on the patients as well.

Mr. Guntly, you mentioned a somewhat different approach that there is a difference between health care and a variety of settings from rural to urban and you mentioned support for having a distinction between the reimbursement ratios. I was reading that into your comments.

I mentioned a couple of the rates. I mentioned the fact that a hernia operation being performed in Okeene—or in Buffalo is a little less than half of what a hernia-type operation would be in Enid.

Do you think those discrepancies or the differences in the rates, say, in that case are justified?

Mr. GUNTLY. I don't want to pick on that particular case at all, but just from what I know about it, if it were my hernia I think I would go to Enid. And what I'm saying by that is I would want the backup of all of the possible services that I could need in that type of surgery.

I would certainly want an anesthesiologist overseeing my anesthesia, and I would want the availability of a competent intensive care unit in case I had a reaction. I would want all these services. I am not sure they are available equally in both places, so I think that those kinds of things are important.

And I personally would not want to provide health care at a lesser degree for others than what I would want for my family, and I don't think that's what these Federal programs were intended to do. I think they were intended to raise the level of quality of care and make it equal. And I don't think it is equal today.

Senator NICKLES. Is there a significant difference, and I'm not familiar with every hospital's DRG rates, but, say, from the DRG rates there in Ponca City from what they might be in Baptist Hospital?

Mr. GUNTLY. I think probably they are in Baptist, yes.

Senator NICKLES. Or in Presbyterian or Mercy?

Mr. GUNTLY. When we originally started out, Ponca City and Blackwell received exactly the same Medicare reimbursements be-

cause they were both considered rural. Now, Ponca City then came up with a rural referral center grouping, which Ponca City Hospital applied for and was accepted. That means a different level of care, a different number of specialists and physicians available, a different number of cases of a higher level, so that now Ponca City does get reimbursed better than Blackwell.

I really can't speak for what they get reimbursed in the cities, and I guess I try not to compare too much to that because I know we're going to lose. I know Oklahoma is the ninth level in the country. We get the lowest reimbursement in the whole United States and, of course, rural Oklahoma is going to be the very last.

Senator NICKLES. You are making many of the points that I've been making. Oklahoma, as a group, has been on the bottom end of the payment scale, and the rural communities are on the bottom end of the Oklahoma reimbursement rate.

I have a real problem with that. I have a problem with it because we want and we really demand the same quality of health care that they receive in New York or in any other State in the Nation. As evidenced by some of the surgeries that have been performed in this hospital in the last few weeks, we do have quality health care.

But a lot of these discrepancies that are built into the reimbursement ratios are going to continue. Even in some cases, if you look at the percentage increases in the DRG's as proposed or will come if they're not changed in the allocation formula, we're going to increase that discrepancy where our State, and particularly our rural areas will continue to receive less and less and other areas more and more.

I don't want people to feel like they need to go into other States for quality medical care. That's not the case today and I don't want it to be the case for tomorrow.

One other comment, when you mentioned Blackwell and Ponca City, it is somewhat analogous to the Wetumka and Holdenville situation where you do actually have a couple of hospitals in close vicinity. Economically one has to weigh, whether there are too many hospitals in one area? And that's one that Kay County is wrestling with, Hughes County is wrestling with, and other areas.

We also have a situation too in some of our rural areas where it may be the only facility within hours. If you are looking at a delivery of a baby or if you are looking at an emergency treatment, you need to have that access to care within some fairly close proximity. It may not be 10 minutes but still, you know, just the quality of health care.

We don't really want to see policies—or at least I don't want to see in the future—that would continue to discriminate to such a fashion that you lose more and more rural hospitals to the extent that you would have to go to five area hospitals in the State of Oklahoma. I don't see that happening. I just don't like some of the trends that are now set with the reimbursement rates.

Actually, Mr. Hulin, I think you mentioned it or maybe Mr. Neal did. The present system, because it looks back on past cost, does penalize the most efficient, the most effective, the groups that went out and raised money and built the hospitals, not with borrowed money but actually did it with some fund raising drive. The

present system penalizes them and rewards more the hospital that goes deeper into debt and has the greater burden to carry.

Again, we have to look at policies. Does that make sense penalizing the efficient and rewarding those that haven't been quite as frugal in the past or as conservative in the past?

I will dismiss this panel, and thank you very much.

On our next panel we have Jon Ihrig, chairman of Health Care Committee of the Chamber of Commerce in Blackwell; Orla Flaker, senior citizen advocate from Blackwell; Wallace Byrd, who's from Coalgate, OK, physician; and Stephen Peter, who's executive director of Oklahoma Health Planning Commission.

Mr. Ihrig, why don't you begin.

**STATEMENT OF JONATHAN C. IHRIG, BLACKWELL, OK, CHAIRMAN, HEALTH COMMITTEE, BLACKWELL CHAMBER OF COMMERCE**

Mr. IHRIG. Thank you, Senator. I would like to possibly present a little different prospective here. My name is Jon Ihrig. I am chairman of a committee that was established by our chamber of commerce in Blackwell, health care needs committee. Blackwell is a community of approximately 8,700 people.

Obviously, I don't agree with all the comments that Mr. Guntly has made here and I don't want to get into a shouting match with him. But since the announcement of the closing of the Blackwell Hospital as an acute care facility, our community has become extremely concerned as to all of the impact that this will have. And because of this, this committee was formed and we have sought services from experts, we feel, outside the community to assist us in doing whatever is necessary to keep adequate health care in Blackwell.

Our greatest concern is that the loss of the hospital will have a definite economic impact, and I think everybody is in agreement with that. The hospital employs approximately 110 people. I think it's our third largest employer in the city of Blackwell.

Not only do these people that are employed there have jobs and many of them are highly trained and skilled persons, but their spouses also work in the community and the surrounding area, so we're talking about a lot of job loss and economic problem there.

But our main concern is the quality of health care for the citizens of Blackwell. And I know that Mr. Guntly has that same concern. We just see it from different viewpoints.

Our service area—we have conducted a survey. We've obtained the services of the OSU Extension Department and Lou Stacker, with the help of the Health Planning and Systems Agency here in Oklahoma City. Our service area does not, we feel, include any—we're not in the Ponca City service area. Our service area of the hospital in Blackwell—the patients are drawn from Blackwell, Braman, Tonkawa, Deer Creek, Nardin, and communities west of there.

If those people, most of them, did not go to the hospital in Blackwell, it's our feeling that they probably would go to Enid or Wichita or somewhere else. They are not going to go to Ponca City for

health care. So we feel like we definitely have a service area that we draw from and that we do serve and we provide a service to.

The survey indicates that our future patient load will definitely depend upon the number of physicians that are located in Blackwell as well as population growth. The last 3 or 4 years the Blackwell area has experienced approximately a 2-percent population growth each year and this trend is predicted to continue at least for the next 5 to 10 years.

Our elderly care is a major problem and this type of care will also continue. We do feel strongly that without a hospital that we will not attract new doctors, and I know this is contrary to what Mr. Guntly thinks. Doctors want to locate close to the facilities they use.

We presently have five physicians in Blackwell, all of which are—the youngest one, I think, is 57 years of age. So they are going to be approaching retirement age before long and we're concerned about finding physicians to replace them.

We did have three young physicians in Blackwell that we did lose. And I think that the reason that we lost all of those physicians were many factors, but one of which was because the hospital declined to provide some of the services that they were promised when they came there. I'm not saying that's the only reason but that is one of the reasons.

The hospital—it depends upon the quality of care that they want to provide. I think they can provide whatever quality of care they want to. I recognize the trends, the increased costs, the problems with Medicare. That's why we're here today. And I don't know anything about the hospital side of the story and I wouldn't try to argue that, but without the doctors we feel like our community will suffer.

If we are fortunate enough to have a doctor in Blackwell that has staff privileges in Ponca City, you are talking about a minimum of 2 hours on the road each day. That doctor is going to take 30 minutes to drive over there in the morning, 30 minutes to visit patients, 30 minutes back again in the evening to make rounds, and that doesn't count any emergency situations that might arise.

And we feel that's a definite deterrent to enticing the doctors to locate in Blackwell. It's just not hardly worth it. We feel like without doctors the community will suffer. There will be a loss of other persons, both professional and otherwise, that will not want to locate.

I definitely think that industry does look at health care, and I don't think industry has been called upon to support health care in this community, and all I can speak for is Blackwell. But certainly we do have industry and I think any industry has to be concerned with the type of care they would receive if there were an industrial accident, how close this care would be.

We're not a metropolitan area. We don't have all the urban streets and roads. In the middle of winter it's not uncommon that our community is iced in or snowed in for a day or so, and you may be talking about life and death, and an emergency room facility may not be sufficient to take care of the patients that need the facility. And because of the weather conditions or otherwise, that 30-minute travel may turn into an hour or an hour-and-a-half or 2-

hour drive, and it may mean the difference of whether or not they will make it.

I think our survey that we've done shows a very important consideration to be that if a patient goes to a physician in Blackwell, he is going to be admitted to a hospital in Blackwell, a local hospital. Without that physician and without that hospital, we are not going to have either one. It's a catch-22 situation, the way I see it. You've got to have both of those things or you don't have either one of them.

We've got many elderly people, and Orla Flaker will probably speak to this, but we have a lot of people in our service area that are quite elderly. They don't drive. Their loved ones and spouses have extended stays in the hospital. To force them to go another 20 miles to Ponca City is another hardship that we feel needs to be considered.

It's just simply our feeling, and the chamber has gotten behind this, and we just don't feel like the regional medical concept is sufficient to meet all of the health care needs of the community. And I'm not saying it's a bad concept; I'm just saying that there are other needs to be considered, and I hope I've enumerated some of those.

We're taking steps in our own situation to do what we can to maintain a hospital in Blackwell. And in our case we've taken steps to obtain a certificate of need, and we're in the process of preparing the application and filing for that and, if necessary, do what we need to do to build a hospital or have a hospital there.

And we feel like the community support and the support from the surrounding communities is sufficient to do that. I think that efficient use of the hospital can support a hospital in a small rural community.

I think there's a lot of fat in any type of program that can be cut, and it's not going to provide all of the answers, but I think that's a place to start, and perhaps your committee has something they can do. And we just feel like we need to address some of these problems and we can't abandon the people that are out there counting on us. And I thank you for being here today.

Senator NICKLES. Thank you very much. Mr. Flaker.

## STATEMENT OF ORLA FLAKER, BLACKWELL, OK, SENIOR CITIZEN ADVOCATE

Mr. FLAKER. Thank you. Glad to speak to you. I was asked to speak on behalf of the senior citizens and I feel, without boasting, that I'm qualified. I've worked for 15 years or thereabouts since my retirement working with the senior citizens in our community of Blackwell.

We have a recreation center we put together, a nutrition program we put together. We have one of the finest housing complexes for senior citizens I think there is in the State of Oklahoma. And I want to brag on that, even if I did put it together, and we've done an awful lot for our people.

As I visit with the people whom I know well, they're heartbroken to think that they have to leave the town for medical purposes. And I might add something here, that I'm not going to go into this

expense and so on and so forth of the hospital proposition, but I talked to the folks about ambulance care.

And the ambulance care at Ponca City costs $111. Now, if you have to go and get that patient and bring him back to Blackwell, that's another $111. Now we're not talking about all the little things they add on, like $10 here and $30 there and $20 and $12 and so on and so forth, until it gets to be an astronomical bill. So there's a lot of things there that the senior citizen just can't afford and that we should look at.

Now, I have a letter here from a Mrs. Holder and I have a letter that she sent to you and you can read it later. I think it's identical.

Dear Senator Nickles: On behalf of the Hillcrest Manor Nursing Home, I must express our opinion in regard to the need to have a hospital in the city of Blackwell. The elderly people of Blackwell and surrounding area depend on the use of our community hospital, particularly in conjunction with the nursing home. Time after time we utilize the services of the hospital and the city ambulance to transport residents who are ill. Now a trip takes 5 minutes and costs $75 one way. That's within the city limits. If the hospital closes it doors, it would take a minimum of 20 minutes to reach the nearest medical center at the cost of $150.

I only allowed $111, but $150.

Hillcrest Manor Nursing Home has 110 residents and Blackwell Nursing Home has 71 residents.

I asked her to apply the numbers of people who left those homes to go to the hospital this year, not in 1985, beyond that. And this is what we have.

Hillcrest Manor Nursing Home has 11 residents. Blackwell Nursing Home has 71 residents. Since the beginning of 1985, there have been 30 and 25 patients sent to each hospital respectively. So that's quite a few people who go to the hospital.

The nursing home residents also depend on the presence of the local physician. However, without a hospital, we will not attract new doctors and the one now working in Blackwell will eventually retire, leaving the city without local medical services. The progress of our community will digress as soon as we find ourselves without a hospital. With the longevity, the need to deal with a life and death situation grows daily.

According to the Bureau of the Census, the Kay County population over 65 years of age will increase 5.2 percent the next 20 years. The need for a community hospital will increase proportionately. We must not lose sight of the population. The elderly citizens of Blackwell and surrounding towns need a hospital as much as the children and young adults. All these citizens in Blackwell are integrally part of our community health service.

I might add, in the 1980 census—I went to the chamber of commerce to get these figures yesterday. In 1980, 19 percent of the people in Blackwell were over 65. We're in bad shape. In Ponca City, they were 15 percent. You folks just get along better over there.

So you can see—and add 5.2 percent to 19 percent in the coming years—in 20 years it will be 24 percent of our people will be 65. It's a need that needs to be taken care of and looked into and, as I said in the beginning, we're talking about human needs, not human services, and human needs takes care of human services in many cases. And we sure would hate to lose our hospital.

And if you ever visited one of those old people who have been here in our area—we are really pioneers, as you know. Kay County was put together in the run in 1893, and we have people still living who made that run with their parents.

And so I sure do thank you for the privilege of being here today and whatever we might add on behalf of our senior citizens.

Senator NICKLES. I appreciate your contribution and speaking out for the senior citizens of Oklahoma.

Our next panelist is Wallace Byrd, M.D., from Coalgate, OK. Mr. Byrd.

**STATEMENT OF DR. WALLACE BYRD, COALGATE, OK, ADVOCATE OF SENIOR CITIZENS**

Mr. BYRD. I want to thank you for asking me to be here. And I think the best I could do is ask a very simple favor of you. May I call you Don?

Senator NICKLES. Yes.

Mr. BYRD. You have such a capability of convincing people that I want you to be a messenger from the people of my area, Little Dixie, to Carolyne Davis. I believe her attitude is the major health problem we've all been facing. And I think if you could take this little message that I have put together, which includes, by the way, a copy of a statement I made for a group that Wes Watkins had gathered together.

We need friends in Washington on both sides, both political parties, and we're very happy to entrust you, if you would, Don, to take a little letter to Carolyne Davis, which I have given to Laura. The most I can do is perhaps read a comment or two at the end of it.

When the Oklahoma Legislature, the Oklahoma Health Systems Agency, and the doctors of this State have all asked that Oklahoma be only one payment area instead of five areas as now, and when it is noted that inequities from this system result in greater out-of-pocket expense for the rural residents for the same medical care as obtainable in the city, whereas those in the rural areas have paid just as much into Medicare, is it not only inequitable but probably unconstitutional to continue such a system?

May I mention at this point that discussing that on the panel with Wes Watkins, Representative Ike Skelton of Missouri took that point up and he said that Carolyne Davis with a stroke of the pen could correct the E.I. problem, but he felt that legislation was necessary to get the root out. And he said that he had introduced a bill or prepared a bill for introduction on that point—I don't know just the substance of it, but you might sometime want to check with him.

Ms. Davis, would you please relent in your attitude toward rural America so we rural doctors and hospitals may no longer have to fear that we have been targeted for extinction without the privileges usually accorded to an endangered species?

Lincoln said, "God must have loved the common people; he made so many of them." In the spirit of Lincoln, who said, "The best way to destroy your enemy is to make him your friend," we doctors and

hospitals, people of rural Oklahoma, beg you, Ms. Davis, give equality of reimbursement to Oklahoma. Thank you.

Senator NICKLES. Dr. Byrd, I may just want to take you with me and we may be more successful than all of the Senators and Congressmen put together. And you can always call me Don. I tried to get my kids to call me Senator and they wouldn't do it.

Our next panelist that we have, and I'm trying to move forth quickly because actually our time is out for this room and for the hearing, is Stephen Peter, who is executive director of Oklahoma Health Planning Commission from Oklahoma City.

**STATEMENT OF STEPHEN PETER, OKLAHOMA CITY, OK, EXECUTIVE DIRECTOR, OKLAHOMA HEALTH PLANNING COMMISSION**

Mr. PETER. Mr. Chairman, I notice the time is 11:31 and your hearing is to end at 11:30. I'm not sure what that tells me.

I have brought with me what my commissioners would call a care package, which contains a number of materials, documents in it, that might be of interest to you as you look further into the rural health care problem.

The only comment that I would like to bring to your attention that's not already been offered is that under the National Health Planning and Development Act, as I'm sure you know, all the States are required to develop a State health plan once every 3 years.

The Oklahoma Planning Program has been in the process of developing the new 1985 State health plan since early 1984. The Oklahoma Health Planning Commission, the Statewide Health Coordinating Council, the Oklahoma Health Systems Agency, and the Governor's office have all been very involved in this.

Just today, this afternoon or tomorrow, the document known as the Preliminary State Health Plan will go forward to a number of recipients leading toward a hearing on May 6th here in Oklahoma City to move toward final adoption of the State health plan. One of the issues of great concern that's addressed in that plan, as directed by the State Health Coordinating Council last fall, is the issue of rural health care.

And if this plan document is adopted in May in its present form, I think one of the things that the planning program will be taking a hard look at in the weeks ahead and in the months ahead is the State legislation now on the books, licensure laws, regulatory provisions that govern the operation and structuring of health care facilities, with an eye toward trying to make those—with an eye toward trying to identify ways in which these programs, these legislative programs, could be liberalized in such a way as to accommodate a more flexible use of health care facilities.

Part of the problem with rural hospital facilities is there are some fairly clear limits on just what can be done with such a facility. If it reaches the point that it needs to undertake some dramatic changes and still deliver primary care to the people of that community, there are some licensure limits on the ways you can use that hospital facility.

And one of the things we will be looking at very carefully is possible revisions in State law that would accommodate a more liberal

approach to the way we use health care facilities in the State. And those would be my comments.

Senator NICKLES. I could ask you questions for about an hour, and I apologize that your time is so short. I usually run the hearings a little tighter and I don't talk as much. So I apologize to all of our panelists on this final panel for not having more time to get into a discussion.

But, Mr. Peter, I have been one that in the past has questioned whether we needed the health planning commission and whether or not the certificate of needs were really, in final analysis, an asset or a liability. I know many in the hospital community have shared that sentiment in the past, some with a great deal of passion.

I don't know if that is still the case today. Quite frankly, I haven't heard as many people talking about it in the last year as I did 2 or 3 years ago. Possibly, the system is working better now or it's been more accommodating. I asked two or three of our panelists today how long did it take and some of them wished it would be quicker, but it wasn't an insurmountable amount of time.

We also had several people talk about converting portions of their rural hospitals into skilled care facilities needing to be approved. I would just hope that the health planning commission would show as much flexibility in working with a lot of these facilities that are having a very difficult time financially because of the declining populations and census of patients and so on.

I would hope that the commission would show flexibility in working with them, trying to accommodate them and to help. I think all of us share the same common goal, and that is that we want to have, quality health care in the State of Oklahoma, whether it be rural or whether it be urban.

And certainly the focus of this hearing is on rural areas, but we want quality health care throughout the State of Oklahoma. The rural areas are experiencing more of a crisis situation today than any other place and, again, this is due to Oklahoma being on the bottom end of the totem pole nationwide.

It is a challenge and the health planning commission is just one of the players. I'm hopeful and confident that you and the commission will work with these hospitals, administrators, and others in trying to facilitate their needs as quickly as possible.

To all of our panelists—there were several people that raised their hands. And anybody with a comment they would like to have in the record? I know I see some friends and some other people that wanted to make a statement. I apologize. Usually if I say we are going to conclude a hearing by a certain time, I like to do it then, because some people have made plans accordingly.

We are scheduled to have a luncheon over at the Hilton Inn that several people have RSVP'd on. Quite frankly, I don't doubt there's people here that didn't get word of that. If you are interested in attending that, you are welcome. There's a limited number of seats, but hopefully we would be able to accommodate everybody at least that indicated a desire to do so, especially those from out of town.

How many people are planning on attending the luncheon, just for my information? I think we have accommodations for that group, but if there's others that wish to join, I would hope that

they will. This is a Dutch treat lunch. Just to give us a chance on a less formal basis, one that's not on the congressional record, to talk about some of the problems and also some of the solutions.

I'm not just interested in talking about the problems. I'm very interested in making some progress toward finding some of the solutions.

I don't doubt that this little letter, that must be about 100 pages, may well have some of the answers to it. Certainly I think the urban/rural discrepancies is a major part of the solution. Perhaps we can get some changes made there, not just in the hospitals but also physicians. We will work on those.

Again, this hearing and the whole reason why I've been having all of these health hearings is because I believe health care and health issues are very important now and 5 years from now they are going to be even more significant.

The demographics you mentioned, Orla, the demographics in Blackwell, is the same thing nationwide. Our health care providers and professionals are doing a good job. We have quality health care in America today. We actually have the best health care system anywhere in the world, and we have an outstanding system in the State of Oklahoma.

As a result of that, people are living longer, people are healthier. We're interested in access, we're also interested in equality. And, we're also interested in the taxpayer and how can we make it affordable for Americans.

We do have some challenges and, the demographics of it are such that you are going to have more and more people entering in this primarily senior citizen category and a limited number of people who are going to be paying the bills.

Accommodating both groups is a challenge, but it's the right type of problem to have. It's the good type of problem to have, somewhat like agriculture. We have difficulty in agriculture today, but it's in oversupply instead of a shortage or a famine. And many countries are wrestling with the latter. I would much prefer wrestling with the former, although it doesn't diminish in any respect some of the challenges that we have in agriculture and in rural America.

With that, I think I will adjourn the hearing. Again, I want to thank all of our panelists and all of our guests today. If someone wants to submit additional testimony, they can send it to my office, Senator Don Nickles, in care of Laura Clay. Laura is here. You can give it to her today if you have it. As always, whenever we have a hearing, we end up taking a lot of stuff back with us and we will be happy to do that.

If you wish to submit additional statements to have it added to the record, let us know. We will keep the record open probably for about 4 weeks for additional comments, to complete it.

So with that, the committee is adjourned. Thank you very much.

# APPENDIX

## MATERIAL RELATED TO HEARING

### Item 1. Letter From Roy D. King, M.D. Holdenville, OK

GENERAL SURGERY
AND
GENERAL PRACTICE

I.R.S. NO. 73-1006691

ROY D. KING, M.D., INC.
711 NORTH BULLITT
POST OFFICE BOX 897
HOLDENVILLE, OKLAHOMA 74848
PHONE 379-6666

April 10, 1985

The Honorable Don Nickles
6327 Dirksen Senate Building
Washington, D.C., 20510

Attention: Laura Clay, Legislative Director

Dear Senator Nickles:

First, may I please tell you how much I appreciate your time, your interest, and your efforts regarding Medicare reimbursement inequities for rural communities of Oklahoma. Your Senate hearing was informative and hopefully another step toward equalization within our state. At the close of the hearing, you stated that additional information could be supplied to be included in the congressional record. I would like to have this letter included in the information gathered at that hearing.

From the testimony given, I think perhaps the misconception that it is significantly less costly to practice medicine in a rural location than in an urban setting is finally being disproved. Certainly our overhead costs are equal to and in some cases, even greater than the corresponding costs in an urban practice. For example:

a. We use the same utilities companies--Oklahoma Gas and Electric Co. and Oklahoma Natural Gas Co.

b. Our interest rates for capital investment and equipment purchases are bank financed and tied to Chase Manhattan prime interest rates.

c. Our medical supplies are purchased through the same major suppliers, such as Mid-Continent Surgical Supply and Melton Co. But in rural Oklahoma we have additional transportation costs and we do not have the advantage of volume or quantity purchasing that some large urban groups have. In this instance, rurel overhead costs are even grester.

d. All insurances such as health and dental; workman's compensation; professional liability and property insurances are secured through the same companies or agencies as urban physicians.

e. There is no decrease in tax rates to rural physicians by either Internal Revenue or the State of Oklahoma for income taxes, for franchise taxes or payroll taxes.

Simply stated, it is certainly as costly to practice medicine in rural Oklahoma as in the urban areas of Oklahoma. But in spite of this, rural physicians and their patients are penalized by Medicare for living outside the large cities. In comparing payments made by Medicare for a routine office visit, for example, it is found that an Oklahoma City physician is approved by Medicare for 44% additional fee for the same service; in fact, the Oklahoma City physician is approved for 25% more payment than the Holdenville physician's entire fee.

The 9004 office fee in Holdenville is $12.00 of which $10.40 is approved by Medicare and 80% of that approved amount is actually paid to the physician or to the patient. My step-father was seen in an Oklahoma City office for the same physical exam, 9004, and the fee was $15.00 (which is a very nominal amount for an urban physician) and Medicare approved the entire $15.00 and

and then reimbursed 80% of that approved fee. Medicare approved $3.00 more for the urban physician than the rural physician charged in total and approved $4.60 more for the same service rendered in Oklahoma than in Holdenville.

We have Medicare explanation of benefits that show the same or greater discrepancies for hospital care, surgical care, in fact, all aspects of medical services. Table I is attached giving some of these comparisons.

There are even tremendous variables in the Medicare allowances within the same medical facilities paid to different physicians practicing side by side. Within our clinic of three physicians there are up to 18% difference in allowable reimbursement from Medicare for the exact same services rendered. Table II is enclosed supporting this statement.

Now may I explain the basic purpose of my letter. We have discussed through correspondence and through meetings and hearings that these discrepencies in the rate of reimbursement from Medicare are grossly unfair to rural physicians. But on the other hand, we have only touched on an even greater injustice. When the physicians do not accept assignment, and this is true in the majority of instances, it is the patients themselves who suffer from the lower approval rates by Medicare for rural practices.

The senior citizen living in Holdenville and the senior citizen living in Tulsa are suppose to have the same insurance coverage under this federal program and they certainly pay the same premium rate for part B Medicare coverage. However, the patients who live in the small towns are discriminated against in at least two ways by this double standard of reimbursement of Medicare funds between urban and rural medical services.

A. First, the patients who live in the rural areas must pay a greater percentage of their medical care costs than do their counterparts living in urban areas.

Using the same example given above regarding the 9004 office visit: The Holdenville office visit is $12.00; Medicare allows $10.40 and reimburses the patient 80% or $8.32 leaving the patient a net cost of $3.68 of the $12.00 he must pay himself. However, the Oklahoma City visit is $15.00 and Medicare approved all of it and pays 80% or $12.00 leaving the patient a net cost of $3.00.

The Holdenville senior citizen has therefore, paid $ .68 or 23% more for the exact same medical care than the patient living in Oklahoma City. This is above even the additional $3.68 the Federal Government has paid for the same care. My point is that "Grandma Jones" living in Holdenville pays more out-of-pocket money for her medicare care than "Grandma Smith" living in Oklahoma City pays. Yet they are suppose to have the same medical insurance under Medicare's federal plan and they pay the same amount of premium for that coverage.

B. There is a second manner in which rural senior citizens are discriminated against because of this double standard:

When "Grandma Jones" is hospitalized in the Holdenville Hospital, the hospital is paid a significantly less DRG payment than the Tulsa or Oklahoma City hospital is paid when "Grandma Smith" is hospitalized. In order to survive under this much smaller DRG payment, the Holdenville Hospital must eventually cut back on services. Such services as physical therapy or respiratory therapy must be discontinued. The next time "Grandma Jones" is hospitalized she will probably receive less services than in the past and certainly less services than will "Grandma Smith" because "Grandma Smith's " hospital could afford to retain all their services. Again, these two women are suppose to have the same insurance coverage. "Grandma Jones" is penalized for living in rural Oklahoma.

The hearing held on April 9th clearly stated the plight of hospitals and even physicians of rural Oklahoma under the present payment methods of Medicare. But little was said concerning the plight of the elderly citizens of Oklahoma themselves and how unfairly this inequity in reimbursement treats them. If equalization can not be obtained because community hospitals are failing due to inequities in Prospective Payments and Peer Review Standards; or if equalization can not be obtained because it presently discriminates between physicians of the same training, same abilities, and same overhead costs; then perhaps equalization can be granted because of the unfair way it treats the very recipients it was created to assist--our senior citizens.

Again, thank you for an opportunity to express ourselves to you and the concern and efforts you are expending toward righting this wrong. If we can be of further service in these efforts please advise us. I would be greatly interested in learning more about the possible "pilot study" you referred to in the hearing.

Respectfully,

Roy D. King

Roy D. King, M.D.

RDK:bk

Enclosures (2)

TABLE I.

URBAN AND RURAL COMPARISON OF MEDICARE ALLOWABLE FEES

| | FEE | MEDICARE ALLOWABLE | PERCENTAGE ALLOWED | 80% Paid by Medicare |
|---|---|---|---|---|
| 1. Office visit, routine, 9004: | | | | |
| Dr. King, Holdenville, routine medical exam | 12.00 | 10.40 | 86% | 8.32 |
| Dr. Hyde, Oklahoma City, routine urology exam | 15.00 | 15.00 | 100% | 12.00 |
| Dr. Hopkins, Oklahoma City, routine eye exam | 34.40 | 32.40 | 94% | 25.92 |
| 2. Lab: Routine Urinalysis* | | | | |
| Dr. King, Holdenville | 7.00 | 6.00 | 85% | 4.80 |
| Dr. Hyde, Oklahoma City | 8.00 | 7.50 | 93% | 6.00 |
| *(lab payment schedule has been amended under Deficit Reduction Act--prior to change Ok City physician allowed more than rural charged) | | | | |
| 3. Hospital visits, routine 9025: | | | | |
| Holdenville physician with 2 hospital visits per day | 20.00 | 14.50 | 72% | 11.60 |
| Oklahoma City physician with 1 hospital visit per day | 33.00 | 25.60 | 78% | 20.48 |
| Hospital exam above routine 9029: | | | | |
| Holdenville physician | 40.00 | 36.00 | 90% | 28.80 |
| Oklahoma City physician | 113.00 | 58.50 | 52% | 46.80 |
| 4. Surgery: | | | | |
| A. (different procedures shown but of same difficulty, same time involved and same unit value) | | | | |
| Dr. King, Holdenville, malignant lesion | 225.00 | 108.30 | 48% | 86.64 |
| Dr. Hyde, Oklahoma City, TUR, bladder neck only | 500.00 | 430.90 | 86% | 344.72 |
| B. (Surgery with immense difference in time and value) | | | | |
| Dr. King, Holdenville: Abdominal surgery including 3 procedures; 8 hr surgical time and 16 hospitalized days of post-op care: | 1823.00 | 1205.70 | 66% | 964.56 |
| Dr. Hyde, Oklahoma City: Prostate Surgery of 1 hour surgical time plus 2 days post-op hospital care: | 1000.00 | 876.90 | 87% | 561.32 |

The diagonal line shows that greater fee is approved in most instances by Medicare for the urban physician than is even charged in total by the rural physician.

TABLE II.

VARIABLES IN MEDICARE ALLOWANCES
EVEN WITHIN THE SAME CLINIC

| | Fee | Medicare Allows | Allowable Percentage |
|---|---|---|---|
| 1. Office visit, routine 9004 | | | |
| Dr. Lucas | 12.00 | 12.00 | 100% |
| Dr. King | 12.00 | 10.40 | 86% |
| Dr. Fennema | 12.00 | 10.40 | 86% |
| 2. Office visit, over and above routine, 9005: | | | |
| Dr. King | 17.00 | 15.00 | 88% |
| Dr. Lucas | 17.00 | 12.40 | 72% |
| Dr. Fennema | 17.00 | 16.00 | 94% |
| 3. Initial Hospital Visit, 9022 | | | |
| Dr. King | 70.00 | 61.90 | 88% |
| Dr. Lucas | 70.00 | 50.00 | 71% |
| Dr. Fennema | 70.00 | 51.50 | 73% |
| 4. Hospital care 2 visits/day 9026: | | | |
| Dr. King | 20.00 | 16.50 | 82% |
| Dr. Lucas | 20.00 | 18.00 | 90% |
| Dr. Fennema | 20.00 | 20.00 | 100% |
| 4. Nursing Home Visit | | | |
| Dr. King | 20.00 | 10.40 | 52% |
| Dr. Lucas | 20.00 | 12.90 | 64% |
| Dr. Fennema | 20.00 | 15 00 | 75% |

Item 2

UNITED STATES SENATE
RURAL HEALTH DELIVERY
HEARING

APRIL 9, 1985
Oklahoma City, Oklahoma

Statement By:
Richard E. Butler
Administrator
Memorial Hospital
Guymon, Oklahoma

My name is Richard E. Butler, from Guymon, Oklahoma.

First of all, Senator, I would like to thank you for the opportunity to provide feedback on problems small rural hospitals face in Oklahoma.

I am the administrator of a rural 58 bed county owned hospital, Memorial Hospital in Guymon. Memorial Hospital has been in existence as the sole provider of acute hospital services in Texas County for over 30 years. During that time it has always been a self-supporting hospital.

Since the inception of the Medicare program, Memorial has participated as a certified provider of acute hospital care. Currently, under the Prospective Payment System, Memorial is averaging approximately 62% reimbursement of Medcare patient bills. The basis for this reimbursement level is the base year hospital costs utilized by the Medicare program. Subsequent to the base year, Memorial Hospital implemented a number of upgrades such as increased numbers and levels of staff, an intensive care unit, ultrasound services and facility remodeling. Unfortunately, these costly upgrades, accomplished after base year calculations were completed, are not included in Memorial Hospital's reimbursement methodology, therefore keeping payments made under the Prospective Payment System at minimal levels.

Additionally, particularly for small, rural hospitals such as Memorial, high cost cases which exceed D.R.G. reimbursement levels by thousands of dollars, can be catastrophic. For instance, Memorial has had several cases in the $ 30,000. through $ 50,000. range. The highest D.R.G. reimbursement amount, however, including outlier reimbursement, has been $ 9,000. For a facility whose budget is approximately $ 300,000. per month, it only takes a few losses of such magnitude to have a serious financial impact.

Since physicians are becoming increasingly aware of the costs of providing care, many times attempts are made to transfer patients requiring extensive treatment or prolonged specialized care to larger institutions with more appropriate capabilities. On several occasions, however, these institutions have refused to accept such transfers.

Additional complicating factors for small rural hospitals include Professional Review Organization guidelines and Medicaid reimbursement levels. The P.R.O.'s guidelines include increased emphasis on out-patient surgery, reduction in some surgical procedures, pre-admission reviews, post-discharge reviews, monitoring of causes of death by D.R.G., and review of all antibiotic use. Such reviews make physicians wary of admissions which are not critical or of emergent nature, increase dependence on written criteria rather than medical necessity, and leave the ulitimate decisions as to coverage with physicians far removed from Guymon. Paperwork seems to take priority over treatment, approvals over wellness, and paper shuffling over health care provision.

Medicaid also contracts with the P.R.O. for reviews of medical necessity for admission, requiring much the same lengthy paperwork and documentation as for Medicare--but for $ 246.00 per patient day, regardless of diagnosis, substantially less than the daily average cost of providing care at Memorial Hospital.

The impacts of the Prospective Payment reimbursement rate described, the P.R.O. and Medicaid's low reimbursement rate have been fairly dramatic. Length of stay averages are down approximately 10% over pre-prospective payment system length of stays. Pre-admission testing, increased out-patient surgery, reduced numbers of in-patient tests and procedures, and, of course, earlier discharges are all results.

While these may seem positive, there are negative aspects. Shorter lengths of stay means sicker patients being discharged, either to nursing home beds or home. When nursing home beds are not available or adequate family support is unavailable, patients remain in the hospital longer than Medicare determines necessary, meaning patients are denied Medicare coverage and incur in-patient costs as a result. With the only local nursing home in Guymon being full and having a waiting list, no full service home health services available, and Memorial licensed for too many beds to participate in the swing bed program, the hospital, physicians and Medicare patients and their families must contend with unpleasent alternatives. Physicians and the hospital are blamed by patients and families for inappropriate discharges and increased patient costs. A complicating factor is the constant barrage of supplemental insurance advertisements, guaranteeing coverage of all hospital costs that Medicare fails to cover. We have seen patients with as many as twelve supplemental policies which they believe will cover all in-patient charges Medicare does not. The unfortunate fact is that it is illegal for these policies to cover the difference between the D.R.G. payments and a higher hospital bill.

Pre-admission testing and more out-patient surgical procedures also seem positive from a cost standpoint. However, Medicare is increasingly monitoring the use of out-patient facilities by Medicare patients with an eye to reducing such utilization. If the physician feels such testing is medically necessary, on what basis can Medicare state such testing is inappropriate?

Out-patient surgery, particularly with the advent of the Professional Review Organization, is seen as a panacea for in-patient surgical costs for certain procedures. In its glee to cut costs, this state's P.R.O. initially stated that hernia surgery, hemmorrhoidectomies, and even amputations of the lower limbs were appropriate out-patient procedures. One hundred eighty-three (183) procedures remain as those which, according to the P.R.O., may safely be done on an out-patient basis.

Emphasis on reduced numbers of tests also seems an appropriate goal in a cost cutting sense, but is a missed fracture or tumor diagnosis worth the savings? Is the resulting patient suffering and potential malpractice action against the physician and hospital, not Medicare, worth the savings? Perhaps those far removed may think so, but I, for one, do not. Since when can bureaucratic regulations and guidelines effectively dictate to a physician how he or she should practice medicine?

Due to reduced revenues to hospitals and the resulting emphasis on cost cutting, Memorial Hospital has had to undertake the following measures in order to remain viable: departmental reductions in worked hours, a freeze on hiring and wages with reduction in benefits; major equipment acquisitions halted; contract management of two departments terminated; and contract physician coverage of the hospital's emergency room cancelled.

In order to provide access and linkage with nursing home levels of care, Memorial attempted to contract for constant nursing home bed availability without success. As stated, Memorial looked at swing beds, but we are too large. We sought to have the Public Health Department home health service fill the continuity of care void, but they are limited by budgetary as well as regulatory restrictions. Consequently, although faced with tight budgetary constraints of its own, Memorial is starting a home health service despite the fact that revenue to offset start up and operational costs is not projected to begin for some six (6) months.

Unfortunately, the plight of Memorial Hospital is not unique. Certainly, better management, coupled with reductions in personnel, supplies and equipment can be initiated without a marked detrimental effect on patient care. But with the need to upgrade equipment, hire and train qualified personnel, have first rate facilities and provide quality services-- how can the federal government say that reducing Medicare and Medicaid expenditures is serving any humanitarian purpose whatsoever? For Medicare patients, hospitals, and physicians, the answer has to be that it cannot make any such claim.

If the federal government truly wants to reduce costs, it should do what should have been done at the outset of the Medicare program--establish a sliding scale of rates for coverage based on ability to pay and require private insurance companies to participate in the program as a percentage of their gross health insurance business.

Again, thank you for your interest and concern, and for this opportunity to be heard.

Item 3.

SENATOR NICKLES, MEMBERS OF COMMITTEE, LADIES AND GENTLEMEN:

WE ARE FROM A SMALL RURAL HOSPITAL IN NORTHWEST OKLAHOMA. OUR COMMUNITY IS APPROXIMATELY 27 MILES FROM A LIKE MEDICAL FACILITY. APPROXIMATELY 60% OF OUR PATIENT VOLUME IS MEDICARE, NEEDLESS TO SAY WE ARE VERY CONCERNED ABOUT ANY CHANGES IN THE MEDICARE PROGRAM.

WITH YOUR PERMISSION AND PATIENCE, I WOULD LIKE TO ADDRESS FOUR AREAS OF CONCERN TO THE RURAL HOSPITAL AND PHYSICIANS WHICH ARE AS FOLLOWS:

1. SECOND OPINION LAW.
2. TRAUMA CODE.
3. VARIANCE IN DRG PAYMENTS.
4. VETERAN'S HOSPITALIZATION IN LOCAL HOSPITAL.

I.SECOND OPINION LAW:

IN RECENT WEEKS I HAVE HEARD MUCH DISCUSSION FROM COMMITTEE HEARINGS ON THIS BILL. IN A RURAL AREA SUCH AS OURS, SEVERAL THINGS MUST BE CONSIDERED.

1. NUMBER OF PHYSICIANS IN COMMUNITY. 2. MILES TO NEAREST MEDICAL FACILITY.---

3. GUARANTEE OF PAYMENT FOR SECOND OPINION.

KEEPING THESE THINGS IN MIND, A FAIR AND EQUITABLE SYSTEM CAN BE ESTABLISHED.

II. TRAUMA CODE:

AT PRESENT THE HCFA PROGRAM MAY SUSPEND A TRAUMA CLAIM FOR 90 DAYS. THIS IS DONE TO EVALUATE ANY OTHER COVERAGE THE RECIPIENT MAY HAVE IN ADDITION TO MEDICARE. THIS MEANS THE CLAIM WILL PROBABLY NOT BE PAID FOR AT LEAST 120 TO 150 DAYS FROM TIME OF SERVICE. AT TIMES, CASH FLOW BECOMES A CRITICAL PROBLEM WHEN 90% OF ALL REVENUE COMES FROM THIRD PARTY PAYORS. WE ARE SEEING AN INCREASING NUMBER OF CLAIMS SUSPENDED FOR THIS SO CALLED TRAUMA INVESTIGATION, THEREFORE WE FEEL THE EVALUATION TIME MUST BE LOWERED TO NO LONGER THAN 30 DAYS.

IN THIS AGE OF ELECTRONIC COMMUNICATIONS THIS SHOULD BE ADEQUATE TIME TO RESPOND TO ANY CLAIM.

IN THE PRODUCTS AND SUPPLY AREA OF HEALTH CARE, WE MUST PAY FOR THE PRODUCTS OR SUPPLIES WITHIN 30 DAYS TO MAINTAIN A SATISFACTORY RY CREDIT LINE SO WHY, SENATOR NICKLES, MUST WE STRUGGLE 120-160 DAYS FOR PAYMENT FOR OUR SERVICES.

III. D.R.G. VARIABLE RATES:

ONE OF THE MAJOR AREAS OF CONCERN WITH THE PRESENT SYSTEM IS THE VARIANCE IN PAYMENT FROM PLACE TO PLACE. IF ONE WILL INVESTIGATE THE QUALITY OF CARE, EQUIPMENT AND PERSONNEL USED IN A RURAL HOSPITAL INVOLVING THE PROCEDURES THAT WE DO, ONE WILL FIND THEY ARE NO DIFFERENT THAN THE LARGE MEDICAL FACILITY. ON THE OTHER HAND, PROCEDURES WE ARE NOT STAFFED OR EQUIPPPED FOR, WE DO NOT ATTEMPT. THEREFORE THE REIMBERSMENT PART SHOULD BAE THE SAME FOR LIKE PROCEDURES OR SERVICE. THIS NEEDS URGENT INVESTIGATION.

THANK YOU FOR YOUR TIME.----------

E. P. Clapper Medical Center, Inc.

Waynoka, Oklahoma

Senator Nickles,

In recent committee hearings a coming problem has been addressed, the alarming number of aged veterans that will be needing hospitalization.

It appears there will be a shortage of available beds for these veterans. The question is, do we spend tax dollars to build new facilities, or do we utilize existing beds? Hospitals all over this country have surplus beds due to many factors such as, new federal regulations, shorter length of stay and changes in private insurance coverage.

Senator, we feel a reimbursment system should be established between the Veteran's Administration and the private hospitals. Therefore our veterans can remain at home among family and friends without the inconvience of traveling to the larger cities.

Respectfully,

John Parker,
Administrator of
E. P. Clapper
Memorial Medical
Center, Inc.
Waynoka, Oklahoma